Kentucky Adult Targeted Mental Health Case Management Training Manual

This Manual Edition Prepared by:
Kentucky Department for Mental Health and Mental Retardation Services
Division of Mental Health and Substance Abuse
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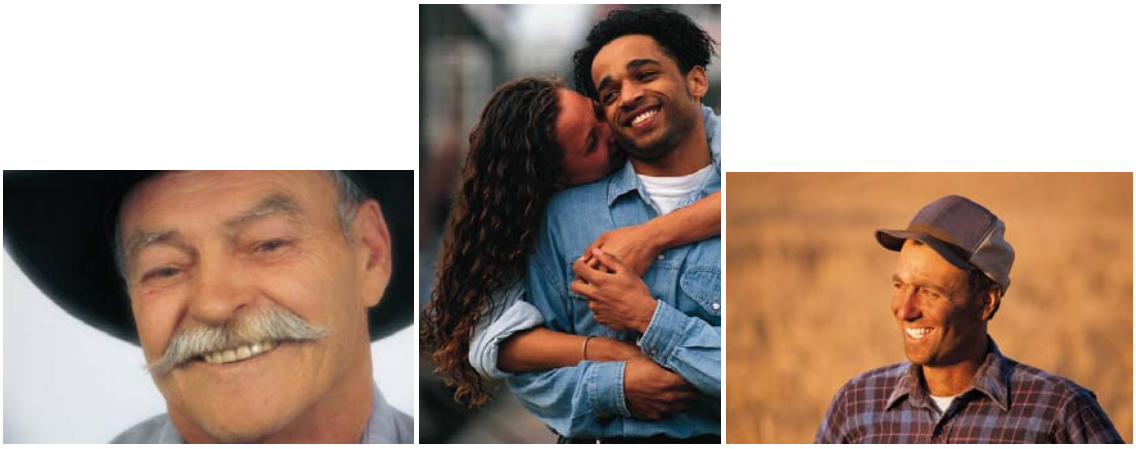

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Libby Clayton
Christy Bland
Amy Hinton
Beverly Loy
Camille House
Suzie Southern
Kevin Ryan
Sandra Silver
Tim Hawley
Thomas Beatty

Department for Mental Health and Mental Retardation Services
Division of Mental Health & Substance Abuse
100 Fair Oaks Lane, 4E-D
Frankfort, Kentucky 40621-0001
502/564-4456
502/564-5777 (TTY)
502/564-9010 (FAX)

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Introduction

This manual was written to help prepare you for one of the most exciting and important jobs in community mental health today. It will serve as a guidebook and resource manual that you can use as a companion in your work as a case manager. Like any new textbook or course of study, this manual should be considered just a beginning and is not intended to provide all of the knowledge, skills and information that is necessary to provide excellent quality case management services. It is intended to provide a basic overview of the service, information necessary for compliance with statutes and regulations, and a knowledge base upon which further training, education and supervision can build

CONTENTS

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APPENDIX

UNIT 1: MENTAL ILLNESS

Description:

This unit presents the federal and state definitions of mental illness, the different types of mental illnesses, and the medications and medication management of mental illness. Topics discussed include diagnostic criteria, symptoms of mental illness and potential side effects of medication.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Identify federal and state definitions of severe mental illness.
2. Describe the different types of severe mental illness.
3. Identify potential side effects of medication.
4. Identify ways to increase adherence to medication.

SECTION 1: DEFINITIONS – Who are persons with a mental illness?

Kentucky funding of case management services for adults limits the provision of the service to adults with a severe mental illness. Therefore, it is critical that case managers and their supervisors understand the working definition of severe mental illness.

The **Federal definition** of severe mental illness, published in the Federal Register, May 20, 1993:

"adults with a serious mental illness are persons:

- *age 18 and over,*
- *who currently or at any time during the last year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to merit diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders.*
- *that has resulted in functional impairment which substantially interferes with or limits one or more major life activities."*

These disorders include any mental disorders (including those of biological etiology) listed in the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases equivalent with the exception of DSM V-codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic living skills (e.g. eating, bathing, dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses.

Kentucky's statutory definition (KRS 210.005) defines mental illness as follows:

"'Mental illness' means a diagnostic term that covers many clinical categories, typically including behavioral or psychological symptoms, or both, along with impairment of personal and social function, and specifically defined and clinically interpreted through reference to criteria contained in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) and any subsequent revision thereto, of the American Psychiatric Association. 'Chronic' means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both."

Psychiatric diagnoses are categorized by the **Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Text Revision.** Better known as the DSM-IV, the manual is published by the American Psychiatric Association and covers all the mental health disorders.

The manual lists the known causes for the disorders; as well as statistics in terms of gender, age at onset, prognosis, as well as some research concerning the optimal treatment approaches. The diagnosis is separated into five axes. Each axis represents an aspect of functioning.

Axis I - Clinical Disorders (includes all mental health conditions except developmental disorders and personality disorders)

Axis II - Personality and Developmental Disorders

Axis III -General Medical Conditions (used to report any major medical conditions that may be relevant to treatment of the mental health disorder)

Axis IV- Psychosocial and Environmental Problems (for example, problems with primary support group, social environment, educational problems, housing problems, economic problems, occupational difficulties, legal difficulties, or transportation difficulties)

Axis V - Global Assessment of Functioning (a general indicator of the individual's overall level of functioning)

A person may suffer from more than one Axis I disorder. The majority of diagnoses that fall within the criteria of severe mental illness are found on Axis I; however, Axis II psychiatric disorders may qualify if there are sufficient functional difficulties, an extended duration of problems, and continued reliance upon publicly funded services and supports (Hodge & Giesler, 1997).

Another classification system found in many medical settings is the *Tenth Revision of the International Classification of Diseases* (ICD-10). The ICD was developed by the World Health Organization (WHO) to classify diseases and other health problems. Although it is less detailed than the DSM, it is the official international classification system for psychological disorders. The codes and terms used in the DSM-IV are fully compatible with the ICD-10.

Criteria for Severe Mental Illness

1. **Diagnosis** - one of the following DSM-IV-TR eligible codes:
    a. Schizophrenia and Other Psychotic Disorders (295.xx; 297.1; 298.9)
    b. Mood Disorders (296.xx)
    c. Other (DSM_____) within state and federal guidelines

2. **Disability** - impairment in *two or more* of these domains of functioning:

   a. Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores.

   b. Interpersonal Functioning: How well the person establishes and maintains personal relationships including those made at work and in the family settings as well as those that exist in other settings.

   c. Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture.

   d. Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.

   e. Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, sex, and culture. A person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.

3. **Duration** - *one or more* of these conditions of duration shall apply:

   a. Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or

   b. The individual has been hospitalized for mental illness more than once in the last two (2) years, or

   c. There is a history of one or more episodes with marked disability and the illness is expected to continue for a two year period of time.

SECTION 2: TYPES OF MENTAL ILLNESSES

Presentation of Severe Mental Illness

It is important to remember that individuals with a severe mental illness are not symptomatic all the time. If not entirely symptom free, they may have a low level of symptoms that are, at times, manageable. An important function of case managers is providing sufficient monitoring so that the consumer experiencing an episode of their mental illness can be referred to appropriate treatment as early as possible and hopefully prevent hospitalization. Therefore, it is important for case managers to have some awareness of, and knowledge about, the various types of serious mental illnesses that our consumers may have, and be able to recognize symptoms. We will highlight several of the most prominent disorders but recommend that case managers become familiar with information found in the DSM-IV-TR.

Case managers do not diagnose or provide mental health treatment. It is important to always consult with your supervisor and/or the consumer's clinician.

Psychotic Disorders

The common characteristics of these disorders are symptoms that center on problems of thinking. The DSM-IV-TR describes two broad categories of symptoms: positive and negative.

> Positive symptoms represent the presence of something extra that people do not ordinarily experience, including delusions, hallucinations, disorganized speech, and bizarre behavior.
>
> Negative symptoms represent the absence of something that people ordinarily experience, and is evidenced by affective flattening, poverty of speech, social withdrawal, and decline in personal hygiene and grooming.

The most prominent (and problematic) symptoms of psychotic disorders are delusions and hallucinations.

> Delusions are false beliefs that significantly hinder a person's ability to function. For example, they may believe that people are trying to hurt them, or they may believe they are someone else (a CIA agent, God, Superman, etc.).
>
> Hallucinations are false perceptions that can appear in any sensory modality – visual, auditory, olfactory, gustatory, tactile, or mixed. The most common hallucinations associated with psychotic disorders are auditory and are often experienced by the consumer as "hearing voices."

Types of Psychotic Disorders

Schizophrenia – This is one of the most common of the psychotic disorders and one of the most devastating in terms of the effect it has on a person's life. Symptoms may include the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, social withdrawal, lack of interest, and poor hygiene.

Schizoaffective Disorder **–** Another psychotic disorder in which symptoms that meet the criteria for schizophrenia are present and during which, at some time, there is either a Major Depressive Episode, or a Mixed (Manic) Episode concurrent with symptoms of schizophrenia.

Delusional Disorder **–** A psychotic disorder in which a person experiences a non bizarre delusion for at least one month. This type of delusion involves a situation that could occur in real life (for example, being followed or watched, poisoned, loved at a distance, or having a spouse that is cheating on them).

And other psychotic disorders such as Brief Psychotic Disorder, Substance Induced Psychotic Disorder, and others.

Mood Disorders

The disorders in this category include those where the primary symptom is a disturbance in mood, where there may be inappropriate, exaggerated, or a limited range of feelings or emotions.

Everyone gets down sometimes, and everybody experiences a sense of excitement or emotional pleasure. However, when a person has a mood disorder, feelings or emotions are to the extreme.

Many consumers with mood disorders function very well in outpatient settings though they may be hospitalized for brief periods.

Depression – Instead of just feeling down, the consumer might not be able to work or function at home, they might feel suicidal, lose their appetite, and feel very tired or fatigued. Other symptoms may include: loss of interest, weight changes, changes in sleep and appetite, feelings of worthlessness, loss of concentration, and recurrent thoughts of death.

Mania – This includes feelings that would be more towards the opposite extreme. There might be an excess of energy where sleep was not needed for days at a time. The consumer may be feeling "on top of the world," and during this time, the consumer's decision - making process might be significantly impaired and expansive, they may experience irritability and have aggressive outbursts, although the consumer might think they were perfectly rational.

Bipolar Disorder – A person with Bipolar disorder cycles between episodes of mania and depression. These episodes are characterized by a distinct period of abnormally elevated, expansive, or irritable mood. Symptoms may include:

- inflated self-esteem or grandiosity
- decreased need for sleep
- more talkative than usual
- flight of ideas or a feeling that their thoughts are racing
- distractibility
- increase in goal-directed activity
- excessive involvement in pleasurable activities that have a high potential for painful consequences (i.e. sexual indiscretions, buying sprees)

Individuals who have recurring manic episodes will frequently have a problem keeping jobs or having stable relationships. Their behavior may get them into financial trouble or even result in criminal charges. When experiencing mania, the person will often have great difficulty making decisions that are in their best interest.

The depressive phase of this illness can also be quite devastating and if the depressive episode follows a manic episode, the contrast can be unbearable. Individuals with bipolar disorder can experience severe depressive symptoms and may at times be a significant risk for suicide.

- (Assessing suicide risk will be covered in Chapter 9)

Personality Disorders

Individuals with Personality Disorders have symptoms and personality traits that are enduring and play a major role in most, if not all, aspects of the person's life. These individuals have personality traits that are inflexible and cause impairment in social or occupational functioning or cause personal distress. Symptoms are evident in their:

- thoughts (ways of looking at the world, thinking about self or others)
- emotions (appropriateness, intensity, and range)
- interpersonal functioning (relationships and interpersonal skills)
- impulse control

Personality disorders are listed in the DSM-IV-TR under three distinct areas, referred to as "clusters." The clusters are listed below with the types of symptoms or traits seen in that category and the specific personality disorders included in each cluster:

Cluster A – *odd or eccentric behavior.*
It includes: Paranoid, Schizoid, and Schizotypal Personality Disorders.

Cluster B – *dramatic, emotional, or erratic behavior.*
It includes: Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders.

Cluster C – *anxious, fearful behavior.*
It includes: Avoidant, Dependent, and Obsessive-Compulsive Personality Disorder.

Because of the way that individuals with Personality Disorders from Cluster B present, they are frequently referred for case management services. Many of these individuals have a dramatic presentation and exhibit a high level of use of services including hospitalization. It is important to do a careful needs-assessment with these individuals to make sure they can benefit from case management services. It may be contraindicated to provide a long-term supportive service. However, they may benefit from short term targeted services such as referrals to vocational programs, assistance with paperwork for entitlement programs, etc.

Personality Disorders offer a unique challenge. A thorough needs assessment and consulting with your supervisor is critical when providing services to individuals with Personality Disorders. For personality disorders that do not fit any of the specific disorders, the diagnosis of Personality Disorder NOS (not otherwise specified) is used.

SECTION 3: MEDICATION & MEDICATION MANAGEMENT

Most consumers who have a severe mental illness are prescribed medication. This section is focused on providing basic information about medicines. This section is not intended to make case managers "experts" in medication – physicians and other healthcare professionals spend many years learning about medications, and a brief training such as this will not substitute for this expertise.

Rather, this section is intended to help case managers understand the importance of medications, some of the warning signs of problematic side effects, and a few tips on improving medication adherence.

Case managers should always consult with a physician or nurse regarding any medication issues or problems encountered with consumers on their caseloads.

Why take medications?

Medications are prescribed to modify chemicals in the body whose failure to operate correctly produces symptoms.

What do medications do?

Nerve cells communicate with each other and with other cells in the body by the use of chemicals called neurotransmitters. Most of the medications that people with mental illness take alter how the nerve cells utilize these neurotransmitters. The theory is that problems with neurotransmitters underlie many of the symptoms of mental illnesses.

Symptoms

Impaired Judgment **-** Poor neurological functioning causes problems in logical thinking, clear understandings about cause-and-effect relationships, and awareness of the consequences of one's actions. The result is often poor life decisions. On a day-to-day basis, impaired judgment is often the most disabling of all of the symptoms of mental illness.

Impaired Object Relations **-** Interpersonal Relationships: Individuals with mental illness have impairments in their ability to empathize with others and to respond appropriately in social interactions with others. On a day-to-day basis, impairments in object relations have devastating consequences to successful functioning and quality of life.

Impaired Impulse Control **-** Individuals with mental illness may have difficulty resisting impulses, and may say and do things that create problems for them in the community, with law enforcement, and in relationships with others. The flip-side of impaired impulse control

is impairment in volition – individuals may have difficulty initiating and following through on tasks and activities of daily life.

Labile or Flat Affect - people may be hyper-reactive emotionally, or display little or no emotional reactivity. Labile or flat affect may not reflect people's internal experience – the expression of emotion is disordered, not necessarily the subjective experience of emotion

Depersonalization - Experiences of unreality and distortions in perceptions. Individuals may have a sense of being outside themselves, of a tilting or other strange perception of external reality, of a slowing or speeding up of the passing of time, a dullness or numbness, etc. People often have a difficult time describing depersonalization experiences, but episodes of depersonalization are very disruptive to day-to-day functioning.

Anxiety - A physiologically-based increase in arousal that produces extreme discomfort. Anxiety is *not* the same as worrying, although excessive worrying may occur as the result of anxiety. Anxiety is the least effectively treated symptom in most programs that serve people with mental illness, and causes immeasurable suffering.

Obsessive-Compulsive Symptoms - Obsession consists of thoughts that tend to pervade a person's consciousness which interfere with other cognitive tasks. Compulsions are actions that an individual feels compelled to carry out that have little or no functional value.

Aggressiveness - May occur as a result of the effect of one or more of the symptoms previously discussed (such as, persecutory delusions combined with impaired judgment, anxiety and impaired impulse control). Medications may be prescribed to reduce aggressiveness, although the medication's action is actually aimed at the underlying symptoms that may be producing the aggressiveness.

Medication

Medications are prescribed to reduce or eliminate these symptoms. Some symptoms may be quite effectively ameliorated by medication (hallucinations or florid delusions), while others may be only minimally affected (impaired judgment, impaired object relations). While symptom reduction is the desired effect of medications, many psychiatric medications also have unintended effects.

Unintended Effects

Unintended effects are often referred to as "side effects". Sometimes side effects are so severe as to be called "adverse effects". Negative side effects can significantly reduce people's quality of life, and some can be dangerous to people's health. Some of the medications that people take are intended to treat the side effects that are caused by the medications that they are taking to treat their symptoms of mental illness.

Side Effects

The Patient's Reality:

> *The drugs I had taken for so many months affected every part of my body. My eyes kept going out of focus, especially when I tried to read. My mouth was dry, my tongue swollen, my words slurred. Sometimes I forgot what I was trying to say. My body was puffy. I hadn't menstruated in months and was able to move my bowels only with enormous amounts of laxatives. I had no energy at all. If walking around in a constant haze is supposed to be tranquility, I was successfully tranquilized.* - Judi Chamberlin

Side effects may be unavoidable with certain medications, but case managers should be alert to the signs of side effects, and should let the physician or nursing staff know that these side effects have been observed.

Some of the side effects that you should watch for are…

Sedation, Drowsiness, Lethargy - Many medications can have the effect of sedating people, making them drowsy and lethargic.

Dry Mouth - Many medications cause dry mouth, which may in turn lead to problems with hydration such as water intoxication.

Sexual dysfunction - Men may experience impotence and/or inability to ejaculate. Women's inability to experience pleasurable sexual activity may also occur. A rare but dangerous side effect in men is priapism.

Constipation or Diarrhea - Disruption of the digestive system is a common side effect.

Insomnia - Some medications may cause sleep disturbances, which are often characterized by early awakening in the wee hours of the morning.

Weight Gain - Some of the newer anti-psychotic medications often produce significant weight gain, and may also contribute to the development of Type 2 Diabetes.

Increased risk for sunburn - It is important to be aware that some medications cause people to be particularly susceptible to sunburn, and they may need additional protections when outside.

Abnormal Movements - A variety of kinds of abnormal movements may occur with some medications, including movements of the mouth, the hands and fingers.

- *Akathesia* - Characterized by restlessness and an inability to be still.

- *Dystonia* - An acute side effect characterized by muscle spasms which are a "stone"-like tightness in the head, neck and eyes. Requires immediate medical attention.

- *Parkinsonism* - Symptoms include masked facies, slowed movement, a shuffling gait, rigidity and drooling.

Agranulocytosis - Occurs in some people who take clozapine (Clozaril). It involves a rapid and dramatic drop in the white blood cell count, and produces a dangerous susceptibility to infection. A drop in white blood cell count may also occur with other medications.

De-Personalization - Just as de-personalization may be a symptom of mental illness, it can also occur as a side effect of medication. People experiencing this may talk about not feeling like themselves, feeling "dead inside", etc.

Tardive Dyskenesia - A type of abnormal movement disorder that occurs frequently with some of the older medications, and often involves movements of the mouth and tongue, tremor and stiffness, and can be irreversible, Tardive Dyskenesia is usually the result of long-term administration of the older medications. Newer medications are often given in hopes of reducing the occurrence.

Neuroleptic Malignant Syndrome - A medical emergency, which usually has a rapid onset, may cause extreme stiffness of the body, and is accompanied by an increase in body temperature up to 105 °F. Individuals with this side effect may have trouble walking or standing, may show delirium or otherwise be incoherent. This is a very dangerous condition that occasionally occurs, most often with older medications and can be fatal.

Adherence and Non-Adherence

A great deal of attention is paid to the issue of adherence – that is, the extent to which people take their prescribed medications in the manner that is prescribed.

Non-adherence may be partial (taking less or more than prescribed, or less or more frequently than prescribed) or total (not taking medication at all). Partial non-adherence is much more common than total non-adherence.

Some interesting statistics:

- Of adolescent cancer patients, **40-60%** fail to take prescribed medication as directed (1986)
- Average non-adherence with epilepsy drug regimens is between **30%** and **40%** with a range from 20% to 75% (1978)
- Only **7%** of diabetic patients adhere to all steps considered necessary for good control (1980)

- Non-adherence by parents to medication regimens prescribed for their children averages **50**%, with a range from 34-82% (1985)
- Among people with high blood pressure, **50**% fail to follow referral advice, **50**% drop out of care within one year, and one-third of those who remain in care do not take enough medication to control their blood pressure adequately (1984)
- **49**% of people who have had heart attacks drop out of exercise programs within the first year (1980)
- Adherence with advised health care practices by healthcare professionals averages **20**%

In other words, non-adherence is a universal problem with all people for all illnesses and healthcare conditions! Why do people with psychiatric disabilities fail to adhere to prescribed medications and practices? Because they are human beings!

That said, there are factors that contribute to greater problems with non-adherence. These include:

Side Effects - If a medication has side effects that the individual experiences as negative, they are likely to have a higher probability of not taking the medication as prescribed.

Confusing Dosing Requirements - Most people with psychiatric disabilities take multiple medications. It is very easy to take the wrong medications in the wrong dosage at the wrong times.

Lack of Understanding of Importance of Medications - Some people may conclude that they do not need medications because they are non-symptomatic – despite the fact that it is the medication that is controlling their symptoms.

What can a Case Manager do to help improve adherence?

Education - If available, the individual can be referred to an educational offering about medications. Otherwise, the Case Manager can consistently emphasize the importance of medication, and convey issues and concerns to the psychiatrist so that information can be provided.

Reminders - If difficulty keeping track of a medication regimen is a contributor to non-adherence, the Case Manager can work with the consumer to set up checklists, tables that show what medications should be taken when, etc.

Tools - Helping consumers to work with pill-minders or other tools to help manage medications can improve adherence.

Simplification of Schedule - If confusing schedule of dosing is a problem, the Case Manager can work with the consumer and their psychiatrist to find ways of simplifying the schedule.

Injectibles - If the consumer simply can not reliably take their medication as prescribed, there may be an injectible form of the medication that can be given to relieve the consumer of the necessity of taking daily medications.

Incentives - With the voluntary agreement of the consumer, an incentive system can be set up to reward adherence.

Supervised Self-Administration - Some CMHCs may allow their Case Managers to provide supervised self-administration of medications. This should be done only with the approval of the supervisor, and with appropriate training and oversight.

A Final Note

Medications are important, but they are not as important as your relationship with the consumer.

If adherence to medication is a point of contention, do not sacrifice the relationship by engaging in a power struggle with the consumer. The power struggle is not likely to achieve the desired adherence, but it is likely to destroy your ability to work effectively with the consumer.

UNIT 2: HISTORY

Description:

This unit describes the backdrop from which case management has emerged as an indispensable element of the mental health service system. Topics discussed include a history of mental health treatment, the community support movement, the definition of case management, and Kentucky's vision for services for adults with severe mental illness.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Identify a brief history of mental health treatment for adults with a severe mental illness.

2. Describe Kentucky's vision and philosophy for services to adults with severe mental illness.

3. Describe the origins and principles of the Community Support Movement.

4. Define Case Management.

SECTION 1: MENTAL HEALTH TREATMENT

History of Mental Health Treatment with Special Reference to Case Management Services

The care and treatment of individuals with Severe Mental Illness in America has evolved over a period of some 300 years. Initially, during the colonial period, care for people who were "deranged" or "distracted", or were considered to be "lunatics" was simply based on providing for basic needs (food, clothing, shelter) and providing control and protection when that was required. This either meant that people with mental illness were cared for by their families, were provided some minimal form of lodging by the town or village government, or were jailed for protective purposes. There were no known effective treatments for mental illness at that time.

The first hospital in British Colonial America was the Pennsylvania Hospital, established in Philadelphia in 1756. While this hospital was established for providing primary health care, provisions were made to house those with mental illness – in the cellar. The first hospital specifically created to house people with mental illness was the lunatic asylum in Williamsburg, Virginia, opened in 1773. Custodial care was the primary purpose of this institution, although various harsh "treatments" were carried out in an attempt to drive the insanity out of the unfortunate inhabitants.

EASTERN KENTUCKY ASYLUM FOR THE INSANE—LEXINGTON.

Kentucky established its first psychiatric hospital in Lexington in 1824, the **Eastern Lunatic Asylum**; Eastern State Hospital, still using some of the buildings originally built in the early 1800s, is now the second-longest continuously operated psychiatric hospital in the U.S.

Over the course of the 19th Century, many approaches to treating and caring for people with mental illness were attempted, all focused on hospital-based care. Kentucky had begun paying private citizens for taking people with mental illness into their homes as early as the 1790s, but no treatment was provided in these settings. The primary treatment approach in the state hospitals of the 19th Century was called "Moral Treatment", which was based on the belief that providing a calm, quiet environment with a highly structured lifestyle was most beneficial to people with mental illness – which was true to an extent, since overstimulation often results in exacerbation of symptoms of mental illness. However, due to funding constraints and disappointment in the outcomes of Moral Treatment (since people were not "cured" by hospital care), most of the state hospitals eventually became little more than warehouses for the mentally ill. Kentucky opened two more hospitals during the 19th

Century – Western State Hospital in Hopkinsville, and Central State Hospital in Louisville – and also opened an institution for the mentally-retarded in Frankfort, opened in 1860 and initially called the Kentucky Institute for Feeble-Minded Children and Idiots, later commonly called Frankfort State Hospital. Kentucky State Hospital was another state psychiatric facility located in Danville, although it was not opened until 1940. Frankfort State Hospital and Kentucky State Hospital have subsequently been closed, but the other three hospitals are still operating.

The focus on hospital care continued into the mid-20th Century, despite many advances in understanding and treatment. These included psychosurgery such as the pre-frontal lobotomy, shock treatments using insulin and electric shock, and finally the introduction of medications in the late 1940s that were effective in treating some of the most problematic symptoms of mental illness. However, few of the people receiving these treatments were thereby enabled to move to the community, because many of their symptoms remained unaffected by these treatments (such as impaired judgment, impaired logical thinking, impaired impulse control), and because of what became known as the "institutional neurosis", wherein people became so dependent on the hospital that they were unable to adapt to community living.

There had long been a recognition that providing support in the community to help people with mental illness when they left the hospital setting was a desirable thing to do, with a social worker being hired to provide "aftercare" to patients being discharged from state hospitals in New York as early as the 1890s – it could be argued that this social worker was the first Case Manager for people with mental illness. However, finding ways to establish and fund services outside hospitals was a vexing problem that was not addressed in any significant way until the 1960s, by which time state hospitals across the country were bursting at the seams with patients. The National Institute of Mental Health had been established in 1946, and some funds were provided by NIMH to communities to provide some services, but these funds were very meager and had little impact on the overall population of people with mental illness. Other than a few isolated specialized programs run privately, there were virtually no public community mental health services in America specifically targeting services to adults with severe mental illness. In 1963, the Community Mental Health Centers Act was signed into law, and this federal law was the catalyst for the creation of the system of Community Mental Health Centers that exist to this day.

Kentucky was in the vanguard of states in establishing a system of Community Mental Health Centers (CMHCs) to take advantage of the opportunities presented by this new federal law. In 1964, **Gov. Ned Breathitt** established a mental health planning commission that mapped out, in a 1966 report titled "Pattern for Change", the basic framework for the CMHC system that exists today. Each of the fourteen regions of the state has a designated CMHC that is funded to provide a wide range of mental health, mental retardation and substance abuse services.

The advent of Medicaid provided a spur to many states to "de-institutionalize" their state hospitals, since Medicaid was a funding source for nursing homes – an enormous percentage of the population of state hospitals by the late 1960s consisted of elderly individuals and those with significant primary healthcare needs, and many of these people were moved to nursing homes, where they were unfortunately simply re-institutionalized. The system of CMHCs, that had been established for the purpose of helping people with mental illnesses to return to their home communities, were ill-equipped to do so, lacking a clear model for care and focusing on many other priorities. Thus, many people who were moved from state psychiatric institutions who were capable of independent living in the community with appropriate supports were not able to do so. Similarly, people with mental illnesses who formerly would have ended up in state psychiatric facilities did not do so, due to the dramatic downsizing of these institutions (in Kentucky, for instance, the bed capacity of state psychiatric hospitals was reduced by 90%). These individuals became the **homeless** mentally ill, the mentally ill inmates of jails and prisons, and the "revolving door" patients who rapidly cycled between hospital and community.

In 1977, officials at the NIMH convened a work group to focus on defining the needs of people with severe mental illness and laying out a vision for the kind of system of services that would be necessary to enable people with mental illness to live in the community, maximize their independence and productivity, and participate fully in community life. This group ultimately defined the "Community Support System", a conceptualization of 10 services that were necessary to provide these needed community supports – one key essential service on the list was Case Management. The list also included out-patient therapy service, vocational services, psychosocial rehabilitation services, housing, crisis intervention, psychiatric services and several others.

The NIMH subsequently established a Community Support Branch, and issued grants to states to facilitate the development of community support services and community support systems. This, along with an increased utilization of Medicaid funding to support community mental health services, resulted in a dramatic increase in the focus on adults with severe mental illness by the CMHC systems across the country, and particularly in Kentucky.

Case Management services in Kentucky began in 1985, with small pilot programs in Louisville and Lexington. Within a very few years, every region in the state had one or more adult case managers. Initially, Case Management services were only funded through state Department for Mental Health funds, but in 1991 the Department for Medicaid Services began paying for Case Management services for Medicaid recipients – this allowed a substantial expansion of the service for both adults and children with serious emotional disturbance.

Case Management has now become an integral component of the service system for adults with severe mental illness, and is likely to remain an essential part of the system for the

foreseeable future. The focus on Recovery as a central goal, and the adaptation of various rehabilitation approaches in out-patient and day programming offers promise of a brighter future for people with mental illnesses.

SECTION 2: THE DEVELOPMENT OF THE COMMUNITY SUPPORT SYSTEM AND CASE MANAGEMENT

In order to move individuals out of the institutional setting and into the community, it was recognized that certain community services would be essential if persons with a mental illness were to live as independently and productively in the community as possible. As stated previously, in 1977 the National Institute of Mental Health defined the 10 services that were to make up the Community Support System, of which, Case Management was a key essential service. Other essential services include out-patient therapy, vocational services, psychosocial rehabilitation, housing, crisis intervention, psychiatric services and several others.

Principles of a Community Support System

- Services should be racially and culturally appropriate. Services should be available, accessible, and acceptable to members of racial and ethnic minority groups and women. This principle is now expanded to include sexual minorities and persons with physical impairments.

- Services should be flexible. Services should be available whenever they are needed and for as long as they are needed. They should be provided in a variety of ways with individuals able to move in and out of the system as their needs change.

- Services should focus on strengths. Services should build upon the assets and strengths of consumers in order to help them maintain a sense of identity, dignity, and self-esteem.

- Services should be normalized and incorporate natural supports. Services should be offered in the least restrictive, most natural setting possible. Consumers should be encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning, and leisure time activities of the community.

- Services should meet special needs. Services should be adapted to meet the needs of subgroups of persons with severe mental illness such as elderly individuals in the community or in institutions; young adults and youth in transition to adulthood; individuals with mental illness and substance abuse problems, developmental disabilities, or hearing impairments; persons with mental illness who are also homeless; and persons who are mentally ill and inappropriately placed within the criminal justice system.

- Service systems should be accountable. Service providers should be accountable to the users of the services and should be monitored to assure quality of care and continued relevance to consumer needs. Primary consumers and families should be involved in planning, implementing, monitoring, and evaluating services. This principle is now expanded to include explicit reference to consumer satisfaction, consumer outcomes and stewardship of public funding.

Definition of Case Management

As Community Support Services developed and evolved, case management services became more clearly defined. There is good agreement about the core functions of case management for adults with mental illness; however, a commonly accepted definition of case management has been more elusive.

The Kentucky Department for Mental Health and Mental Retardation Services has adopted the National Association of Case Management's definition of case management:

> *"Case Management is a practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self-management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of the individual's personal goals for community living."* (Hodge & Giesler, 1997)

This definition encompasses the core functions, recovery focus, and outcomes of case management and is supported by the following definitions from the Kansas Strengths Model and the Psychiatric Rehabilitation Model of case management:

- The Kansas Strengths Model (developmental - acquisition) defines case management as *a form of personalized helping directed at connecting an individual to resources (internal-external) for improving their quality of community life.*

- The Psychiatric Rehabilitation Model defines case management as *a process by which persons with severe psychiatric disabilities receive support in negotiating for the various services that they both want and need.*

There is general agreement about the functions of case management. Each of these topics will be discussed in the following units of this manual. The five essential functions of this service are:

1. Assessment
2. Developing an individualized service plan
3. Linking and coordinating services
4. Monitoring
5. Advocacy

Critical Elements of Case Management Practice

The critical elements of case management have become the method by which both functions and values are operationalized in CM practice. These are important features of CM that must exist regardless of model or level of intensity. These critical elements for the practice of CM include:

1. The emphasis is on intervention in the consumer's natural environment rather than an artificially created environment;

2. The intervention is comprehensive and connotes a whole person (holistic) focus rather than being fragmented by agency demands;

3. The intervention is accentuated by aggressive engagement, follow-up and frequent contact that is based on consumer need rather than agency dictates;

4. Case management focuses on strengths, skills and supports and minimizes weaknesses, but does not overlook them;

5. Case management presumes active consumer involvement as a partner with the case manager in planning and implementing services;

6. The direction of the intervention is based on consumer choice and control of his/her destiny;

7. The case management intervention assumes responsibility for integration of significant others, if the consumer wishes, into the planning, execution and achievement of goals the consumer has set;

8. The case manager reduces involvement commensurate with the consumer's ability to plan for his/her own needs, yet remains sensitive to fluctuations in that ability.

Kentucky's Vision for Adults with Severe Mental Illness

Kentucky's vision for persons with severe mental illness is that they are empowered by their personal and individual choices and capacities, and will be able to live a life of dignity and hope in the community.

Each person will have available options for housing, income, productive work, medical and social services, transportation, education, and personal support equivalent to that of all citizens of the Commonwealth and adequate to meet individual wants and needs. The focus of all actions will be to protect and balance the rights and concerns of consumers, family members, and the larger community and to provide an environment that maximizes community integration and opportunities for acceptance.

Kentucky's Philosophy for Adults with Severe Mental Illness

- Consumers should retain the fullest possible control over their own lives and be empowered to make choices concerning the services and activities in which they will be involved.

- Families are a primary source for support and advocacy at the collective system level.

- The mental health services system should be comprehensive, flexible, culturally normative, and unified.

- The overall human services system should be seamless, continuous, and integrated in a way that consumers experience minimal difficulties in moving among its various components.

- The natural community should be a place where everyone will learn, finally, to live together, to respect each other's differences, to heal each other's wounds, to promote each other's progress and to benefit from each other's knowledge.

UNIT 3: CASE MANAGEMENT

Description:

This unit will review the concept of recovery as it applies to people with severe mental illness and provide an overview of the values and principles that drive and energize case management practice reviewing the Strengths Model of Case Management. Major activities of the case management process will also be presented and illustrated. One of the important concepts in the field of mental health is the idea that people can recover from even the most severe mental illness. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. It also means regaining rights and taking personal responsibility.

Objectives:

1. Describe a recovery-oriented system of care.
2. Describe the five key concepts in recovery.
3. Describe the values and principles of the Strengths Model of Case Management.
4. Describe the four major activities in the case management process
5. Understand the importance of the consumer/case manager relationship

SECTION 1: PHILOSOPHY OF RECOVERY

For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Assumptions about Recovery (Anthony, 1993)

- Recovery can occur without professional intervention.
- A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
- A recovery vision is not a function of one's theory about the causes of mental illness.
- Recovery can occur though symptoms reoccur.
- Recovery is a unique process.
- Recovery demands that a person has choices.
- Recovery from the consequences of the illness is sometimes more difficult than the illness itself.

Key Concepts in Recovery (Copeland, 1994)

The essential principles of recovery are:

- Hope – Consumers need to believe that change and a better life is not only possible, but attainable.

- Personal Responsibility – Consumers need to feel they can control their own lives and take responsibility for their own care.

- Education – Consumers need information about their illness and treatment options.

- Support – Consumers need support from friends, family, professionals, and the community.

- Self-Advocacy – Consumers need to reestablish control over their life, rights, and responsibilities.

Recovery often depends on the consumer finding someone who believes in him or her. When a case manager is able to take that type of supportive and encouraging role with a consumer, it is very powerful and can be instrumental in that consumer's success.

Recovery Definitions

Just as there are many definitions of case management, there are perhaps more definitions of recovery. Here is how some of the leaders of the recovery movement define this process:

- William A. Anthony, PH.D, Executive Director at the Center for Psychiatric Rehabilitation defines recovery as:

  "Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

- The Ohio Department of Mental Health defines recovery as:

  "Recovery is a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

- Molly Clouse, Peer Consultant for the Kentucky Division of Mental Health defines recovery as:

  "A process of regaining one's life to a usable form; to reclaim one's personal power from one's illness."

- The President's New Freedom Commission on Mental Health reports a recovery oriented vision as:

  "A future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community."

- Laurie Curtis (1993), an Independent Consultant and Associate Graduate Professor at Trinity College of Vermont describes recovery as:

  "a process not a place. It is about recovering what is lost: rights, roles, responsibilities, decisions, potential and supports. It is not about symptoms elimination, but about what an individual wants, how s/he can get it, and how others can help/support them to get there."

Recovery-Oriented Service System

A recovery vision of service is grounded in the idea that people can recover from mental illness and that the service delivery system must be constructed based on this knowledge. In the 1980s, two events ushered the concept of recovery from mental illness into the 1990s: (1) the large number of consumers who were writing about their own recovery and (2) the empirical work in the 1980s of Harding and her associates (Anthony, 2000). Prior to these two events, the belief was that severe mental illness, particularly schizophrenia, was a deteriorative disease. Therefore, mental health systems and programs were built around the belief that people with SMI "did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course" (Anthony, 2000).

However, after deinstitutionalization, Courtenay Harding and her colleagues followed a number of long-term research studies that showed that one's actual mental illness had less to do with one's chronicity than the "myriad of environmental and other social factors interacting with the person and the illness" (Harding, Zubin, & Strauss, 1987, p.483). This new concept was supported by a growing body of consumer literature that was woven together with personal accounts of recovery. In 1987, the idea that people can recover from mental illnesses was made official with the publication of the DSM III-R (Anthony, 2000).

As the concept that people with severe mental illnesses can and do recover filtered through mental health systems, so did a variety of concepts about what recovery looked like and how it was to be achieved and by whom. In looking at recovery and how our current system of mental health services support recovery, we will review assumptions about recovery, identify essential services included in a recovery oriented service system, and list key characteristics of a recovery oriented service system.

Essential Services of a Recovery-Oriented Service System

Treatment	–	Symptom relief
Crisis Intervention	–	Personal safety assured
Case Management	**–**	**Services accessed**
Rehabilitation	–	Role functioning
Enrichment	–	Self-development
Rights protection	–	Equal opportunity
Basic Support	–	Personal survival assured
Self-Help	–	Empowerment
Wellness/Prevention	–	Health status improved

Characteristics of a Recovery-Oriented Service System

- The mission of the organization includes a recovery vision that drives services.
- A core set of needed services are identified.
- Consumer and family member satisfaction is measured and important.
- Leadership constantly reinforces the recovery vision.
- Written policies encourage programs to be recovery friendly.
- Service staff is assigned based on competencies and preferences.
- Case Management services are available to consumers who want or need it.
- Consumer goals include functioning in living, learning, working, and/or social environments.
- Consumers are actively sought for employment at all levels of the organization.
- Self-help services are available in all geographic areas.
- Consumers and family members are actively involved in designing services and evaluation.
- Policies insure that the knowledge, skills, and attitude of staff enable them to provide effective, culturally competent care.
- Policies insure that all levels of staff understand the recovery vision and how it impacts services.
- Funds are designated based on consumers' expressed needs.
- Funds are designated based on expected outcomes of services.
- Access to services is based on consumer preference rather than professional preference.
- Access to services does not depend on using a particular mental health service.
- Access to living, learning, working, and social environments outside the mental health system is expected.

SECTION 2: THE STRENGTHS MODEL

The Strengths Model of Case Management assumes that people have strengths, goals, and dreams. The community is viewed as an oasis of resources. Meaningful relationships and access to resources are essential to attaining personal goals. This model values consumer choice, self determination and empowerment. It recognizes the power of the consumer-case manager relationship as a partnership. The model also values assertive outreach and group supervision as effective tools in facilitating personal growth and change.

Principles of the Strengths Model of Case Management (Rapp, 1998)

1. The focus is on individual strengths rather than pathology.

2. The case manager-consumer relationship is primary and essential in the facilitation of growth and change.

3. Interventions are based on the principle of consumer self determination.

4. Aggressive outreach is the preferred mode of intervention.

5. Resource acquisition activities are used to acquire environmental resources.

6. Group supervision is used to monitor consumer progress and foster creativity among case managers.

7. The community is viewed as a resource and not as an obstacle to service delivery.

8. Persons suffering from severe mental illness have the ability to learn, grow and change.

Major Activities of the Case Management Process

Case management services in the Rehabilitation and Recovery Model can be thought of in terms of the following four major activities: coordination, advocacy, linking, and monitoring.

Coordinating with and for the consumer

- Develop a long-term supportive relationship with the consumers.

- Maintain regular contact with consumers ranging from several times a day to once a month contact, depending upon consumer needs.

- Maintain contact with eligible consumers no matter where they reside (i.e., homeless, hospital, jail, group home, own apartment, etc.) through *outreach*, taking the initiative to stay in touch.

- Provide case management services to eligible consumers on a continuous basis, depending on the consumers' needs.

- Discuss and develop a comprehensive service plan for and with each consumer based upon a needs assessment.

Advocating for consumer rights

- Work with consumers to advocate for service improvements when services are judged unfair, inadequate or non-existent.

- Assist consumers in using formal grievance processes, starting at the local level and culminating with the state Cabinet for Health and Family Services ombudsman or Division of Protection and Advocacy, if necessary.

- Bring examples of unmet needs, and possible solutions for meeting such needs, to the attention of mental health decision-makers for their consideration for possible action.

- Encourage and assist consumers to join any advocacy groups in their area or form groups where none exist.

Linking to services

- Become knowledgeable about the community supports and resources available to consumers (i.e., public and private treatment providers, advocacy and self-help groups, low-income housing resources, employment and training programs, financial benefits, etc.) Maintain regular contact with these groups to aid consumer access.

- Work with consumers to:
  - access appropriate treatment programs within local resources
  - obtain all benefits for which they are eligible
  - obtain a satisfactory living situation
  - secure employment training and/or work opportunities and assist them in meeting employment goals
  - obtain needed health care services as well as regularly scheduled physical examinations

- Assist consumers in developing a range of social supports (i.e., consumer self-help groups, families, peers, etc.)

- Encourage family members to get involved with organizations such as the National Alliance for the Mentally Ill (NAMI), local affiliates and/or family support groups.

- Assist family members in accessing mental health and social services programs to meet their own needs.

Monitoring

- Follow-up and evaluate, with the consumer, to ensure that services are meeting their needs.

- Evaluate services, with the consumer, on an on-going basis to assess if the consumer can reach the goals of their service plan.

Case Manager – Consumer Relationship

A primary factor in being a successful case manager is the working relationship. A good case management relationship is based upon trust, mutual respect and a willingness to work together to attain agreed-upon objectives. The primary target for change is not the individual, but the environment. The case manager does not attempt to change the consumer's beliefs, values or emotions, but works with the consumer to improve living conditions. In doing this, the case manager can help the consumer increase his/her skills and expand the individual's horizons. A strong partnership for advocacy, when it is conscientiously pursued over the long term, can change people as well as their environment. The case management relationship, like any other, thrives on consistency, regularity of contact, openness, honesty and the careful building of trust.

The case manager's ability to engage and connect with the consumer is very critical in developing the consumer-case manager relationship. Developing and establishing trusting relationships is an ongoing process and requires a variety of skills. One of the most powerful ways to foster trust is to have genuine respect for consumers by allowing them to make their own decisions, establish their own goals, and set their own pace.

Case managers must develop a belief in the potential for growth in the consumers which they serve. Your attitude about severe mental illness, the people who are diagnosed as having a severe mental illness and the possibility of change are communicated to the person seeking help. You are attempting to form a partnership with the individual, be aware that your actions will influence the development of this partnership. You are a vital participant in the change process and must convey a positive, open perspective if you are to have any impact.

Case managers must be timely, reliable, dependable, and authentic in all their interactions with consumers. Different consumers may want to have different degrees of personal

connections with their case managers. Some may find frequent contacts intrusive; others may need daily support.

Critical elements of engagement:

- Start slow; do not push the consumer to make decisions about services.
- Do not assume that the consumer will know what you mean by case management services, or that they will desire this type of service. The best way to describe what case management is all about is by doing.
- It is essential to initiate a follow-up contact either by phone or by home visit after the first contact.
- If the consumer does not contact you on the agreed upon date, it is your responsibility to reinitiate contact and set a time when you can both get together.
- Use the strengths assessment, described in Unit 5, as a tool to build a partnership with the individual.
- Finally, be willing to talk openly and honestly with the consumer about their illness.

The process of change is slow and will not always progress as you would like. You ultimately are the key, be patient and communicate your willingness to struggle with the consumer as they attempt to adjust. Remember, establishing relationships takes time.

UNIT 4: REGULATIONS

Description:

This unit will define the regulations and requirements for case management services for both DMHMRS and Medicaid, and list the Community Mental Health Center contract requirements pertaining to Case Management.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Identify regulations pertaining to case management.

2. Discuss the differences in DMHMRS and Medicaid regulations and requirements.

3. Identify the CMHC contract requirements pertaining to case management.

SECTION 1: STATE REGULATIONS

Several statutes and regulations exist that govern case management services, as well as the other services that are provided by the Community Mental Health Centers. It is useful to understand the difference between statutes and regulations.

Statutes are laws that have been passed by the legislature and signed into law by the Governor. Statutes are preceded by the letters "KRS", which stands for Kentucky Revised Statutes. For instance, the statute that established in law requirements for involuntary hospitalization for people with mental illness is KRS 202A.

Regulations are promulgated by agencies of state government for the purpose of codifying the details that are necessary to actually implement statutes. Regulations are preceded by the letters "KAR", which stands for Kentucky Administrative Regulations. For instance, the regulations that spell out the details associated with the Department for Mental Health and Mental Retardation Services is KAR 908.

Sometimes the language in the body of a regulation is quite sketchy, but a Manual is incorporated into the regulation by reference. This is the case, for instance, with the Department for Medicaid Services regulation relating to Adult Targeted Case Management Services, which is KAR 907 1:550

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907 KAR 1:515. Targeted case management services for adults with chronic mental illness.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194.050, 42 USC 1396a-d, n

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Human Resources has responsibility to administer the program of Medical Assistance. KRS 205.520 empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation sets forth provisions relating to the coverage of targeted case management services for adults with chronic mental illness.

Section 1. Definition. (1) "Case management services" means services necessary to assist the targeted recipient in gaining access to needed medical, social, educational, and other services.

(2) "Chronic mental illness" means the same as the definition contained in KRS 210.005(3).

(3) "Target group" means the group of Medicaid eligible individuals that are chronically mentally ill (as defined in KRS 210.005) adults, with a diagnosis of a major mental disorder (other than substance abuse or mental retardation as the sole diagnosis) included in the DSM-III R classification.

(4) "Targeted recipient" means a recipient within the target group of chronically mentally ill adults for whom case management services are provided.

Section 2. Case Management Services. The following services shall be covered as case management services when provided by a qualified case manager to a Medicaid eligible recipient in the target group:

(1) Assessment of the consumer;

(2) Participation in development of the consumer's service plan;

(3) Referrals, linkage, and coordination of Medicaid and non-Medicaid services;

(4) Advocacy;

(5) Monitoring;

(6) Reassessment and follow-up;

(7) Establishment and maintenance of case record; and

(8) Crisis assistance planning.

Section 3. Excluded Activities. The following activities shall not be considered case management activities:

(1) The actual provision of mental health or other Medicaid covered services or treatments;

(2) Outreach to potential recipients;

(3) Administrative activities related to Medicaid eligibility determinations; and

(4) Institutional discharge planning.

Section 4. Provider Qualifications. Provider participation shall be limited to the fourteen (14) regional mental health mental retardation centers, licensed in accordance with 902 KAR 20:091.

Section 5. Case Manager Qualifications and Supervision Requirements. (1) Case management qualifications. Each case manager shall be required to meet the following minimum requirements:

(a) Have a bachelor of arts or bachelor of science degree in any of the behavioral sciences, from an accredited institution; and

(b) Have one (1) year of experience in performing case management or working with chronically mentally ill (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and

(c) Have completed a case management certification program (within six (6) months) offered or approved by the Department for Mental Health and Mental Retardation Services; and

(d) Have supervision by a mental health professional (psychiatrist, psychologist, master's degree social worker, psychiatric nurse, or professional equivalent as determined by the cabinet) for a minimum of one (1) year.

(2) Case manager supervision requirement. For one (1) year, each case manager shall have supervision performed at least once a month, both individually (per case plan) and in group (resource development).

Section 6. Implementation Date. The provisions of this administrative regulation shall be applicable with regard to services provided on or after July 1, 1991. (18 Ky.R. 602; Am. 1053; eff. 10-6-91.)

DMHMRS Policies and Procedures Manual Requirements

DEFINITIONS:

17. Qualified Mental Health Case Manager means an individual with a Bachelor's Degree in psychology, social work, nursing, sociology, human services, special education or other behavioral sciences who has completed the Department's case management certification course within six (6) months of employment and who are working under the supervision of a Qualified Mental Health Professional with Department approved case management certification.

18. Qualified Mental Health Professional (QMHP) means a board certified or board eligible psychiatrist, a licensed clinical or counseling psychologist, certified psychologist, a psychological associate, a social worker with a Masters degree in social work from an accredited school of social work, a person recognized as a professional equivalent by the Kentucky Medical Assistance Program, or a registered nurse with

one of the following combinations of education and experience:

A. Master of Science in Nursing (MSN) with specialty in psychiatric, mental health nursing and no experience.

B. Four (4) year educational program, with a Bachelor of Science in Nursing (BSN) and a minimum of one (1) year of experience in a mental health setting.

C. Three (3) year educational program Diploma Graduate with two (2) years of experience in a mental health setting.

D. Two (2) year educational program Associate Degree in Nursing (ADN) with three (3) years of experience in a mental health setting.

Adult Mental Health Case Management

a. All adults with a chronic mental illness, as defined by KRS 210.005, who are discharged from a state psychiatric facility, who are determined by hospital staff to be in need of intensive case management services and who agree to receive those services shall receive the services of a case manager.

(1) The assignment of a case manager shall occur prior to or on the date of discharge. Exception: if the individual refuses the receipt of those services or when the hospital's staff fails to notify the appropriate staff of the Center of the need for this service.
(2) Re-evaluation of ongoing need for intensive case management shall be the responsibility of the Center.
(3) Compliance with this assurance shall be documented in accordance with the appropriate state psychiatric hospitals' aftercare reporting requirements.

b. A written comprehensive needs assessment shall be obtained by face-to-face contact with the consumer, and other family members, as indicated. The assessment shall include:

(1) identifying information (living arrangements, emergency contacts, source of assessment information);
(2) family life (ability to function and interact with other family members);
(3) physical health (note any health problems or concerns, treatments, medications, handicaps, etc.);

(4) emotional health (behavior problem, alcohol/substance abuse, etc. which may be further defined in the treatment plan);
(5) social relationships (support, friends, family, volunteers, recreation, etc.);
(6) physical environment (safety, cleanliness, accessibility, etc);
(7) self-care (activities of daily living, ability to care for one's own needs, functional assessment skills and skill deficits);
(8) educational status (educational needs, vocational needs, prognosis for employment skills);
(9) legal status (guardian, conservatorship, involvement with the legal system);
(10) financial resources (consumer's income or other resources); and
(11) community resources (formal and informal resources in the consumer's community).

c. The case manager shall provide assistance in the development of the consumer's individual service plan. While the case manager shall not be responsible for developing the consumer's individual service plan, it shall be the responsibility of the case manager to document:

(1) all needed services;
(2) anticipated dates of delivery;
(3) all services arranged;
(4) follow-up on services; and
(5) unmet needs and service gaps.

d. Case Managers, whether they are employed part-time or full-time, shall deliver only case management services to adults.

e. The caseload size shall be small enough to permit the delivery of intensive case management services to each consumer given the unpredictability of the manifestations of severe mental illness. The recommended caseload size shall not exceed twenty-five (25) with no more than fifteen (15) consumers receiving the most intensive of service. The maximum caseload shall be thirty-five (35).

f. Caseloads shall be reviewed and reassessed on a three (3) month basis allowing for termination of intensive case management for consumers whose most pressing goals have been achieved. This may also imply transition to supportive case management to be provided by the consumer's friends, family, primary therapist or others. Time dated goals shall be instituted and goals not achieved within one year shall be reevaluated.

g. Minimum standards for the supervision of case managers shall be as follows:

(1) The supervisor shall be a QMHP who has completed the required adult case management certification program.
(2) Supervision shall occur both individually (per case plan) and in group (resource development) at least one (1) time a month.
(3) The supervisor may provide direct case management services in the event of staff absence or position vacancy.

Community Mental Health Center Contract Requirements

1.1 SERVICES:

1.1.3 Assign a case manager prior to or on the date of discharge and provide case management services to all adults with severe mental illness as defined by KRS 210.005, who are discharged from a state operated or state contracted psychiatric facility and who are referred by hospital staff for intensive case management. Services shall begin no later than fourteen (14) calendar days after discharge. All outreach activities shall be documented in the individual's service record. Acceptable performance of this responsibility shall be determined by comparison of hospital and Second Party event data. Exceptions to this requirement are permitted if, after an individual is informed about case management services, the individual refuses the service and the refusal is documented in the individual's service record.

1.1.4 Provide an appointment with a qualified professional on a date no later than fourteen (14) calendar days after discharge to each person discharged from a state operated or state contracted hospital that is referred by hospital staff. If the individual does not keep the appointment, all outreach efforts shall be documented in a consumer record. If the referral specifies psychiatric services, the appointment shall be with a psychiatrist. Acceptable performance of this responsibility shall be determined by comparison of hospital data and Second Party event data.

1.1.5 Provide Community Medication Support Services in accordance with the DMHMRS *Guidelines for the Community Medication Support Program* (CMSP).

1.1.7 The Center shall have a written Consumer Bill of Rights that describes the legal and human rights of the consumers, including a description of the Center's Consumer Grievance Procedure. The Bill of Rights shall be written in terms that most consumers can understand and available in alternative formats. Each consumer shall be informed of his or her rights during intake and this shall be

documented in the consumer record. These rights shall be posted in each facility the Center occupies.

1.1.8 The Center shall have a written Consumer Grievance Procedure that describes the means by which consumer rights are protected and exercised. The grievance procedure shall be posted in each facility the Center occupies and contain the phone number and address of the Center designated Ombudsperson. The Ombudsperson shall serve as a consumer's rights officer for the Center, maintain all grievances in a separate file and make reports of all consumer grievances and their resolution to the appropriate committee of the Center's Board at least quarterly. The Consumer Grievance Procedure shall:

- offer an option to grieve to a person other than the consumer's therapist;
- if requested by the consumer, provide assistance in filing the grievance;
- be limited to no more than three internal appeal steps;
- provide for the consumer to have an advocate present at hearings; and
- inform the consumer of the availability of the Cabinet for Health and Family Services Ombudsman if the consumer is dissatisfied with the final decision of the Center.

1.2.8 Determine if registered boarding homes are meeting the needs of individuals referred to the Second Party who are discharged from a state operated or state contracted psychiatric hospital or mental retardation facility to a registered boarding home in their region.

1.2.8.1 Visit each individual referred no later than ninety (90) calendar days after receiving a written assessment of the individual's needs from the discharging facility and at least once within each ninety (90) calendar days thereafter. Complete a "Boarding Home Assessment Form" provided by the Cabinet for each visit to document if the individuals' needs are being met by the boarding home.

1.2.8.2 If it is determined that an individual's needs are not being met by the boarding home, the Second Party shall refer the individual to the Kentucky Cabinet for Families and Children for a more appropriate placement, and no later than ten (10) working days after a quarterly follow-up visit, make a report in accordance with KRS 210.271(2) to the Office of Inspector General, Division of Community Health Services.

1.3.6 Comply with KRS 202A.400 Duty to Warn.

1.3.7 Comply with 920 KAR 1:070. Deaf and Hard of Hearing Services.

1.3.8 Comply with KRS 210.235 Confidential nature of records and Title 42 Code of Federal Regulations Part 2.

1.3.10 Comply with KRS 620.030 Duty to report dependency, neglect or abuse.

1.3.11 Comply with KRS 209.030. Reporting of adult abuse or neglect.

The next section will go in-depth into Medicaid requirements, which are mostly similar to DMHMRS requirements, but let's briefly talk about DMHMRS. When case management services are going to be billed to the Department for Mental Health and Mental Retardation Services (that is, when the consumer is not a Medicaid beneficiary), there are a few differences in requirements from when the services are to be billed to Medicaid.

The differences are:

Case Manager Qualifications: Case managers with only a baccalaureate degree in a behavioral health field are not required to have the one year's experience in working with adults with severe mental illness.

Caseload Size: While the maximum allowable caseload size of 35 consumers is not different, the DMHMRS does recommend that caseloads be no larger than 25, and smaller if the needs of the consumers on the caseload are more intensive.

SECTION 2: MEDICAID

Medicaid is a joint Federal and state program that assists individuals with low income and limited resources to access healthcare. Medicaid was established under Title XIX of the Social Security Act of 1965. Medicaid in Kentucky is administered by the Cabinet for Health and Family Services, Department for Medicaid Services.

It is important to understand the difference between Medicaid and Medicare:

Medicaid is a state-operated program that utilizes a combination of state funds and matching Federal funds to pay for healthcare services to individuals who meet state and Federal eligibility criteria (which will be discussed later).

Medicare is a Federal program that provides funding for healthcare services to individuals 65 years of age or older, as well as some individuals with disabilities. The state does not play a role in the administration of Medicare.

Medicaid Eligibility is based on specific criteria established in Federal and state statutes.

The Department for Medicaid Services contracts with the Department for Community-Based Services to determine the eligibility of applicants. To be eligible for Medicaid, the individual must be in an eligible group and meet income and resource limits.

Medicaid eligible groups include:

- Persons 65 years of age or older
- Blind or permanently disabled individuals

- Children under the age of 18
- Children in foster care
- Pregnant women
- Aged, blind and disabled individuals who receive Supplemental Security Income (SSI) benefits. All individuals who receive SSI are automatically eligible for Medicaid.

Medicaid income guidelines change annually. Certain medical, work-related and childcare expenses are deductible from an individual's income when applying income guidelines. In addition to income considerations, an individual's financial and other resources are considered in determining financial eligibility for Medicaid. An individual may have no more than $2,000 in checking and savings accounts, cash-on-hand, or in stocks, bonds, certificates of deposit, etc. A couple may have no more than $4,000 in these cash resources.

Other assets may also be considered as resources. However, assets not counted in determining financial resources for Medicaid eligibility determination are:

- A home
- A burial reserve up to $1,500 per person
- Equity in an income-producing non-homestead property up to $6,000 in value
- An automobile used for employment, transportation to obtain medical treatment, or specially equipped automobiles for individuals with disabilities
- Equity in other automobiles up to $4,500

Medicaid makes payments to providers of healthcare services to pay for the cost of services provided to Medicaid-eligible recipients of these services – to be eligible to receive payments from Medicaid, the provider must be actively enrolled with the Department for Medicaid Services as a healthcare services provider. Payment is only made by Medicaid for services specified and approved by the DMS when those services are provided to an eligible recipient.

Medicaid is the payor of last resort – any other source of payment for services for which the individual may be eligible must be billed prior to billing Medicaid. In some cases Medicaid may be able to pay the portion of the billed amount that is not covered by another funding source.

If Medicaid has paid for a service, the provider may not bill the individual for the same service, regardless of whether or not the cost of the service exceeds the cost to the provider of providing the service.

Medicaid Targeted Case Management for Adults

Targeted Case Management for Adults is an "optional" service under Federal Medicaid regulations – certain services must be included in a state Medicaid plan, while others are considered optional, and the state can decide whether or not to have Medicaid pay for the service. Kentucky changed its Medicaid state plan as of July 1, 1991 to specify that Medicaid would pay for targeted case management for adults – prior to that date, Medicaid did not pay for the service.

Medicaid's definition of targeted case management is:

"Services which will assist the target population in gaining needed access to medical, social, educational and other support services."

The target population is defined as adults eighteen years of age or older with chronic mental illness. To view this definition, see: KRS 210.005 Definitions

Eligible Providers

The fourteen Community Mental Health Centers are the only eligible providers for Targeted Case Management Services for Adults. No other provider type or organization is eligible to bill Medicaid for this service.

Caseload Size

The Medicaid Targeted Case Management for Adults regulation specifies that the recommended caseload size is 25-30 consumers per full-time case manager. There is no minimum caseload size, but the maximum allowable caseload size for a full-time case manager is 35 consumers. Any case manager billing more than 35 case management clients during a month is in violation of this regulation.

Case Manager Qualifications

Medicaid has established minimum qualifications that individuals must meet to become Adult Targeted Case Managers. The qualifications include:

1. A Bachelor of Arts or Science degree from an accredited institution with a major in one of the behavioral sciences or nursing. The behavioral sciences include:
   - Psychology
   - Social Work
   - Sociology
   - Human Services
   - Special Education

2. One year experience in performing case management services or working with individuals with chronic mental illness
3. Completion of the Case Management Certification Training within six months of employment

If there are questions about an applicant's college degree being in compliance with the education qualifications requirement, the CMHC should submit an official transcript of the applicant's college credits and a copy of his/her diploma to the DMS for review and approval. A Master's degree in a behavioral science will substitute for the one year experience requirement. Persons employed as case managers as of 7/1/91 are considered "grandfathered" with regard to the one year experience requirement.

100% Rule

While not a qualification, it is important to understand that case managers are barred from providing any services other than case management. That is, case managers may not also provide out-patient therapy services or any services other than case management. This requirement reflects the importance of the case manager role, and is intended to keep case managers exclusively focused on meeting the case management needs of the consumers on their caseloads.

Case Manager Supervision Requirements

Case managers must be supervised by a Qualified Mental Health Professional (QMHP) for a minimum of one year. People meeting the criteria for being Qualified Mental Health Professionals include psychiatrists, psychologists, Master's level social workers, psychiatric nurses, and others. For a detailed listing of which professionals are considered to be QMHPs, see: KRS 202A.011 Definitions. For purposes of eligibility to provide supervision to case managers, individuals who have been determined by the DMS to be "Professional Equivalents" are also considered to be eligible supervisors.

Supervision is to be performed at a minimum of once a month, both individually and in a group format. It is expected that individual supervision will focus on the work of the case manager with their assigned consumers, while group supervision will serve the purpose of sharing amongst case managers regarding resource development.

Supervisors must also complete the Case Management Certification Training.

Consumer Eligibility

For individuals to receive case management services that are paid for by the DMS, they must meet the following eligibility criteria:

- Age 18 years or older
- Meet the state's definition of "chronic mental illness
- Receive case management services from one of the 14 Regional CMHCs

An aside

Making eligibility determinations based on diagnoses is very problematic when there is not what most professionals would consider an obvious severe mental illness diagnosis such as schizophrenia or bi-polar disorder. The definition of "chronic mental illness" would seem to provide support for people who have been given virtually any diagnosis, and the Medicaid disqualification of people with sole substance abuse or mental retardation diagnoses still leaves a wide range of diagnoses that would not traditionally be considered to constitute a severe mental illness.

For instance, could an anxiety disorder be considered a severe mental illness if the individual also met the duration and disability criteria? Many people would argue that this would be an unlikely scenario, but it could possibly occur with a person, for instance, with severe agoraphobia or another persistent and disabling anxiety-related disorder.

Much judgment must be exercised in making these eligibility decisions, and there are few hard-and-fast rules that can be applied. One such rule would be that a person with only a diagnosis of anti-social personality disorder would not be considered to be eligible for case management services, not because they do not technically meet the eligibility criteria (which some individuals might), but because there is no evidence that the Kentucky model of case management service is an appropriate modality of service for such a person. Efficacy should be considered in any case when making decisions about eligibility -funding is far too limited for providers to provide services to individuals who do not benefit from this investment of precious resources.

Needs Assessment

Medicaid requires that a comprehensive needs assessment be obtained, based on information obtained by face-to-face contact with the consumer and, if indicated, other family members. The required elements for the needs assessment include, at a minimum:

- Identifying information (ie., age, gender, contact information, etc.)
- Family life (ie., family configuration, involvement of family members, etc.)
- Physical health status and needs
- Emotional health issues

- Social Relationships
- Physical environment (housing, employment, transportation, etc.)
- Self-care skills and needs
- Educational status
- Legal status (criminal and civil)
- Financial resources and needs
- Community resources – both those currently available and need for additional resources

The requirement for a comprehensive needs assessment must be completely fulfilled through assessment procedures carried out by the case manager and the elements described above must be addressed.

Service Plan

Each consumer receiving case management services must have a service plan. The case manager provides assistance in the development of the treatment plan/service plan. The treatment plan/service plan is developed in response to the case manager's needs assessment and other techniques used for evaluation purposes by service providers and the plan shall be monitored by the case manager.

Covered Services

The Medicaid case management definition specified that the following activities are considered to be "covered services", and therefore paid for by Medicaid when provided to eligible recipients:

- Assistance in the development of the client's treatment plan/service plan
- Coordination of and arranging for needed services as identified in the treatment plan/service plan
- Assisting the consumer in accessing all needed services, whether those services are paid for by Medicaid or not paid for by Medicaid
- Monitoring the consumer's progress. This monitoring shall include:
  - Making referrals
  - Tracking the consumer's appointments
  - Removing barriers that prohibit access to recommended programs or services
  - Follow-up with consumer to assure that services are being received and that the consumer's needs are being met
  - Periodic reassessments of the consumer's changing needs, and
  - Education of the consumer and others of the value of early intervention services and treatment programs

- Performing advocacy activities on behalf of the consumer
- Case consultation as required
- Services to individuals in an institution (hospital or nursing home) that are performed during the month prior to or the month of discharge to community to help in the transition from institution to community
- Crisis assistance
- Monitoring the consumer's treatment plan/service plan, as developed in response to the case manager's needs assessment, and documenting:
  - all needed services
  - anticipated dates of delivery
  - all services arranged
  - follow-up on services
  - unmet needs and service gaps

Services <u>Not</u> Covered

There are some services that are not considered to be case management services by the Department for Medicaid Services. These include:

- Institutional discharge planning. Institutions (hospitals, nursing facilities) are paid for this service. However, the case manager may be of assistance in facilitating the transition from institution to community.
- Transportation of the consumer when the sole purpose of the service is simply transporting the consumer. However, the case manager may provide transportation to the consumer in the process of providing a covered service, as described above.
- Case management services to an individual who is also receiving case management services through another Medicaid program that provides the service, such as the Home and Community-Based Waiver Program, the Supports for Community Living Waiver Program, Hospice Program when paid for by Medicaid, or the Commission for Handicapped Children's Program. In very special circumstances, an individual in one of these programs might receive case management services from a Targeted Adult Mental Health Case Manager, but only in the unusual case where such services were not duplicative of the other case management service and must be clarified in the case manager's documentation.
- The actual provision of mental health or other services or treatments.
- Outreach activities to potential clients.
- Administrative activities and/or processes associated with determining Medicaid eligibility.

Consumer Rights

Medicaid requires that all consumers are afforded certain rights. These include:

- Freedom of choice of case management services. All consumers must sign the **MAP-586** form which certifies that they have been informed of their rights with regard to Targeted Case Management services, their choice to accept or deny case management services and their choice of Targeted Case Management providers and case managers.
- Freedom of choice of participating case management providers – meaning that the consumer can choose which organization to receive the service from. In practical terms, however, the CMHCs are the only eligible providers in each region of the state.
- Freedom of choice of case managers employed by the case management provider. The organization must make a reasonable effort to comply with consumers' preference for case managers, within the limits of capacity.
- Freedom of choice of services providers of any other Medicaid-covered services. The consumer must be afforded the choice of primary care physician, hospital care, etc.
- Involvement of the consumer in the development of their own service plan.

UNIT 5: BILLING & DOCUMENTATION

Description:

This unit describes the billing process for both DMHMRS and Medicaid, and how to document services and maintain records required. Records must be maintained for a minimum of six years, and records are required to be made available to the Cabinet for Health and Family Services upon request.

Objectives:

At the conclusion of this unit, participants will be able to:

1. List the number and types of contacts needed to bill for case management services.

2. List the components of a needs assessment.

3. List the components of service documentation.

Case management services are paid for on a per-month basis – the unit of service for case management is one month. Both Medicaid and the DMHMRS consider that a one-month unit of case management service has been provided when the case manager has made a total of four or more service contacts with the consumer during the course of a calendar month, two of which must be face-to-face contacts with the consumer. The case manager may make more than the four required service contacts during the course of a calendar month, but additional service contacts do not change the billing or payment.

Contacts

Face-to-face contacts consist of personal contact between the case manager and the consumer, in any location.

Non-face-to-face contacts include:

- Telephone contacts with the consumer
- Face-to-face contacts with others (family members, community resources, etc.) on behalf of the consumer
- Telephone contacts with others on behalf of the consumer

Email contacts are not allowable service contacts.

Client Records and Service Documentation

There must be a client record for each consumer receiving case management services. The record must be maintained in an organized fashion and kept in a central location. The following written documentation must be maintained in the client record:

- A written comprehensive needs assessment
- A service plan that documents
  - All needed services
  - Anticipated dates of service delivery
  - All services arranged
  - Follow-up on services
  - Unmet needs and service gaps
- Service documentation to substantiate the services, including
  - The type of case management service provided
  - The date the service was provided
  - The place the service was provided
  - The person providing the case management service
  - The signature of the case manager providing the service (electronic signatures are acceptable)

UNIT 6: SERVICES

Description:

This unit describes the assessment phase of the case management process focusing on how to assess consumer strengths, needs and priorities. This unit also addresses service planning and goal setting, monitoring, advocacy and closure. The long and short term goals are based on the information obtained in the Strengths Assessment and prioritized on the Needs List. The Service Plan provides useful long-term and short-term goals and related actions steps that can be used to support the consumer's recovery process. The involvement of the consumer is critical to the entire process. A case example is provided to demonstrate the implementation of a case management strengths assessment.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Understand how to develop a strengths assessment.
2. Understand how to develop a service plan.
3. List the four global purposes of monitoring.
4. Complete an assessment and service plan.

SECTION 1: ASSESSMENT

Assessment

The assessment process, identification and prioritization of needs should be a cooperative and collaborative process in partnership with the consumer. Unique individual characteristics, values, desires and needs must be taken into consideration. Remember that each step of the model represents a building block for change and the enhancement of growth for the consumers that you serve.

In order to determine what services the consumer needs, an evaluation is necessary. This evaluation is called a needs / strengths assessment. Once this assessment is made, a service plan is developed which outlines long-term goals and the smaller steps that must be taken to achieve those goals.

This strengths assessment is intended to provide a framework from which the consumer can be viewed in positive, growth-oriented terms. The degree to which the consumer is committed or motivated to work with the case manager corresponds directly to the degree to which they are involved in assessing or planning from the beginning.

What is a Strengths Assessment?

- A tool to obtain and represent the ongoing strengths and needs of the consumer, and that person's situation and circumstances including:

1. behaviors indicating danger to self / others
2. daily living skills (ADL's)
3. interpersonal / social relationships
4. mental health and substance abuse services
5. vocational
6. treatment participation
7. medication adherence
8. benefits / financial resources
9. crisis incidents
10. housing
11. medical / health needs
12. educational
13. legal issues
14. transportation

The following questions may help guide the assessment process when meeting with the consumer:

1. What kind of experience has the consumer had up to this time?
2. What is going on now for the consumer?
3. Where would the consumer like to be?
4. What resources can he/she use to make the desired changes?
5. What talents or experience can the consumer use to meet the desired goals?
6. What steps does he/she need to take to make the changes?
7. What is the most important at this time?

The assessment is an ongoing working document and is to be updated when the consumer's status is altered, goals change, or new resources are acquired. This assessment is to be reviewed at least every 90 days.

Developing a Strengths Assessment

There are main areas that should be incorporated into the case management strengths assessment. These will include assessing and documenting the consumer's need for community resources and services. Assessment and services should build upon the assets, strengths, and capacities of consumers in order to help them maintain a sense of identity, dignity and self-esteem. The procedure should be natural and flexible.

- Start where the consumer is. An adult-to-adult relationship accentuates and models effective communication.
- Focus on strengths.
- Select a comfortable environment to conduct the assessment.
- All of the areas should be addressed and prioritized, as per the consumer's ability to participate.
- Ask open-ended questions.
- Involve family members and other significant social resources and natural supports in the process with the consumer's release of information.

Introduction and Exploration

In this initial phase, the case manager will:

- introduce himself/herself to the consumer
- explain the case management process and the goals of this service
- begin to evaluate the consumer's current level of engagement. It should be kept in mind that willingness to participate in case management services is closely

associated with consumer choice. Persons may be temporarily satisfied with their lives and circumstances, and not want to work on more progressive goals and objectives.

- explore the consumer's community and unique situation with respect to present and future needs, past experiences, interests, aspirations and current or previously used skills and resources.

Empowerment and Acceptance

The consumer is the "expert" about their own unique strengths, interests, and aspirations. Case managers can positively influence willingness by fostering hope and belief in the person receiving services. Services and strengths assessments should incorporate consumer self-help approaches, and should be provided in a manner that allows consumers to retain the greatest possible control over their own lives. As much as possible, consumers set their own goals, decide what services they will receive and are active participants in the assessment, service plan development and services provided.

This principle recognizes the consumer's recovery process. Active listening, reflection and verbal support are critical to the acceptance and empowerment of the consumer. In this process the case manager may respond to the information presented by the consumer by reflecting what the consumer said and drawing out strengths. The consumer is encouraged to explore their situation to identify their own personal strengths. For example, "You said you'd like to live in an apartment; tell me what kinds of things you do when you are on your own."

The Strengths Assessment Discussion

The case manager responds to the consumer by moving in whatever sequence is natural throughout the discussion. It could begin with living arrangements and then move to finances. There is no prescribed sequence. The responses of the consumer are used to determine their level of need in the needs assessment. It is important to collect and record details regarding consumer responses. This information can then be incorporated into the strengths assessment.

Since a strengths assessment is ongoing, the case manager may stop the process at any point in order to:

- respond to a consumer's restlessness or unwillingness to continue
- to start the prioritization of needs to move into the development of a service plan
- to set a continuation date / time to gather further information prior to developing service plan

Prioritizing Needs

After completing the strengths assessment, the consumer and case manager must identify which areas should be chosen as priorities for goal setting. These are first based on critical survival needs (food, shelter, clothing, and medical care) and then less critical needs. Once the needs have been prioritized, the consumer and case manager are ready to develop a service plan to accomplish one or more of the goals.

Elements of the Case Management Strengths Assessment Form

The four page Case Management Assessment Form, located at the back of this manual, is divided into three sections: basic information; strengths assessment; and needs / priorities.

Basic Information Section
Identifying information; marital status; education status; sources of monthly income; monthly expenses; insurance coverage; and legal status.

Strengths Assessment
This section is the heart and soul of the strengths assessment process. When used creatively it serves as a tool to assist consumers in developing an awareness of their own strengths and potential. Information from the assessment sets the basis for subsequent steps such as establishing goals and hope. The strengths assessment is designed as a provocative document; it is not just a form to complete but provides questions to assist the consumer in looking at their current situation, their past and where they want to be in the future.

The Categories listed across the top of the strengths assessment form include:

Current Status: *"What's going on now?"*
Resources include community as well as individual strengths; such as SSI, SSDI, who lives with the person, attending GED classes, receiving medication, taking care of a pet, going for walks, belonging to a support group, etc. We frame these resources in a positive way. We do note all resources that can be defined. For example, it is a strength if there is family contact. It is important to collect details about consumer responses. Frequency of activities or resources used, and type of use are important. For example, if a consumer says their favorite leisure time activity is playing basketball, then the case manger needs to find out: 1) if it is in league or with others or if it is shooting baskets by himself or herself; 2) does s/he play daily or once a month; and 3) how long has the person been doing this activity.

Personal Goals: *"Where I'd like to be?"*
Interests and aspirations are, perhaps, the most valuable strengths to be assessed. If the consumer is able to make "I want to..." statements, it is a strength. If the goal appears unrealistic, the first steps toward attainment usually are not. For example, if the aspiration is to be employed, marketable work skills and experience are logical steps toward attainment of that goal.

Resources Internal/External*: "What have I used?" "What can I use?"*
Resources define areas of strengths to which the consumer has access, but which are not currently being used; such as work skills used in the past, membership in a club even though there is no attendance, old friends who have not been seen for some time, ability to cook even though the person is not now cooking, activities enjoyed in the past even though they do not seem of interest at the present time, etc. Again, we do not note what is wrong with any of the accessible resources. They are strengths on which to build. It is not the resource itself that is a strength. It is the individual's willingness and ability to be involved with it that is the strength.

Needs: *"What steps do I take to get there?"*
Initial needs for community living and the development of potential are assessed and noted in this column. This is not intended to be a formal goal statement or resource acquisition plan. Readily identifiable needs to attaining ambitions and resources are noted. Examples of needs which may be noted in this section are: transportation to town, a current membership to the YMCA, an appointment for therapy, paints and brushes, a guitar, or fabric for quilting.

When the consumer and case manager work together to complete the current status and personal goals columns, a good strengths assessment is done. When they complete the resources and prioritized needs columns, the foundation for a good consumer-driven Service Plan will be built.

Each of the four categories listed above provide the format to address four life domains which include:

1. Living Environment
2. Learning Environment
3. Working Environment
4. Social Environment

The strengths-needs list consists of information learned from discussions with the consumer.

"Strengths" refer to what the consumer can do, if there are other people willing to help, and what community resources are available for the consumer.

"Needs" refer to what can be done; they should be stated positively in terms of what the consumer could be doing.

Case 1

Frank is a 46-year old man who has been referred for case management services from the jail. He was recently arrested for disorderly conduct, public drunkenness and resisting arrest, but has been released from jail – his trial is pending. Frank has been arrested, on average, about six times per year for minor offenses over the last several years. Sometimes he is found incompetent to stand trial. When he is found competent, he usually is released for time served.

Frank has a very unstable living situation. Sometimes he lives with his brother, but he and his brother fight a lot, so he usually ends up being kicked out of the house – then he stays wherever he can find to stay, which may be in an abandoned house or car. Frank abuses alcohol and occasionally marijuana and other street drugs when he can get them.

Frank was employed as a farm worker when he was younger, picking up day work on a seasonal basis. He has not worked for a number of years, although he says that he would like to. He receives SSI and Medicaid, but receives no other entitlements or benefits.

Frank completed high school and one year of college. He reads and writes well.

He has never been married, but he did have a girlfriend when he was in his twenties, and he is the father of a 19-year old daughter. They have little contact, and he wishes that he could have a relationship with her.

Case 2

Marsha is a 24-year old woman who is referred for case management services from the state hospital, from which she has been recently discharged.

Marsha lives with her boyfriend, and there is evidence that the relationship involves some domestic violence, although she has never had him arrested nor taken out an EPO. Marsha is dependent on her boyfriend, because she has no income.

Marsha dropped out of high school on her sixteenth birthday, coming from a single-parent home with many siblings. She held many menial jobs, none of which she was able to keep longer than a month or two. She barely reads, and seems to frequently exercise poor judgment.

Marsha has been hospitalized several times this year, with each hospital admission coming sooner after discharge than the last. She didn't appear to be very stable at the time of this current discharge, and she reports that she only has a few days' medication.

SECTION 2: SERVICE PLANNING & GOAL SETTING

The Service Plan: Development and Implementation

Once a needs assessment is complete and needs have been prioritized with the consumer, the identified goals are recorded in a service plan.

What is a Service Plan?

A service plan is a set of action steps designed to achieve one or more of the consumer's goals as stated during the needs assessment.

It is a plan that contains:

- long term goals
- short term goals or action steps
- parameters of service delivery
- review date
- signatures of the consumer and case manager (and supervisor, if needed)

Just as the needs assessment is completed based upon the individual consumer, so is the service plan. Consequently, there are guidelines for completing the plan, but the design and emphasis of the plan is based upon the individual consumer.

The Role of the Case Manager in Designing a Service Plan

The role of the case manager is to:

- assist the consumer to prioritize his/her needs
- establish a goal statement(s) from his/her needs assessment
- identify the necessary action steps to accomplish the goal(s)
- design a plan that will support the consumer progress

Throughout this process the case manager educates and reinforces the consumer's right and responsibility to identify and make choices. Many consumers have such low self-esteem that they feel unable to make important choices for themselves. The case management process should help them reclaim some confidence in their ability to choose. A variety of ways are used to increase consumer ownership of the Service Plan, examples include: consumer writes their own plan; consumer has a current copy; consumer signs the initial plan and subsequent changes; consumer reviews plan on a routine basis to monitor progress; and consumer learns how to use strengths to attain goals.

Each goal must be broken down into a set of action steps. These steps are listed along with who is responsible, and how and when the step will be accomplished. The art of designing a

personal plan is to develop action steps that are small enough, and a plan of support large enough, so that disappointments and failures are minimized.

The following is a checklist for writing quality action steps:

- Are the action steps stated in positive terms?
- Are the action steps realistic and achievable?
- Are the action steps measurable and observable?
- Are the action steps stated in specific terms, not global terms?
- Are the action steps consumer oriented, not case manager oriented?
- Is the initial action step immediate with a high probability of success?
- Are the action steps set in sequential order and serve to accomplish a short-term goal?
- Are the number of action steps small enough to not overwhelm the consumer, but large enough to set a direction and set a challenge?
- Are the strengths identified in the assessment re-stated in the goals?

Once the needs assessment has resulted in a specific, time-limited service plan, the case manager and the consumer begin the exciting process of implementing the plan. Remember that nobody's life can be traced by a straight line! Expect that the plan will need to be changed and revised from time to time.

Implementing the Service Plan

The next step is implementation. Now the case manager and the consumer will utilize resources and services in the community to meet the goals on the Service Plan. The case manager will offer both practical support and encouragement throughout this process.

Offering Support to the Consumer

The most frequently expressed concern of new case managers is the perceived lack of progress of consumers. The "revolving door syndrome," often addressed in literature and expressed in the field, describes consumers who are discharged from the hospital into the community, then sent back to the hospital, only to begin the process again. It must be emphasized that the definition of a good case manager does not rest on consumer change. The ultimate attainment of consumer-based goals rests with the consumer, but the case manager and an active case management system are key players in eliminating obstacles to the consumer's progress. Growth and movement are supported by:

Celebrating Small Steps: Each time a consumer completes an action step a celebration is in order. The celebration may be as simple as acknowledging the success with direct eye contact and a verbal, "Good job, you did it."

Asking the Consumer How You Can Help: Helping a consumer attain goals requires just the right amount and kind of assistance. Sometimes helping can be unhelpful if it conveys a

message of incompetence or unworthiness. The case manager's job is to help in a way that strengthens the consumer and the relationship.

Staying in Touch: Depending on the resources of each CMHC, the consumer can generally make contact with a member of the case management team or another mental health professional 24 hours a day. Of course, the case manager is not on duty 24 hours a day. However, staying in touch often means following the consumer both into and out of crises, acute care and long term hospitalization. Active outreach to the consumer is a cornerstone of case management.

Go With the Flow: A case manager must support changes in consumer choice even it involves more time and energy in paperwork. Completing the small action steps, celebrating successes, building community supporters, rehearsing a problem solving process, and having someone they trust to help them survive in the community are the real goals. "'Going with the flow" requires not only patience but also a clear understanding of case management and a true commitment to serving consumers.

Making Changes Which Address Lack of Progress

When progress through the goals stops, it is a signal that something is wrong with the goal that is not being achieved. A few questions may help the case manager and consumer diagnose the specific barrier(s):

1. Are the tasks not made discrete (small, specific) enough? Is the consumer expected to do too much?

2. Is the consumer too anxious to perform the task? Is more support needed? Should the tasks be restated?

3. Is the goal or task what the consumer wants? Does the goal or task need to be redefined or deleted?

4. Are significant others either being supportive or being non-supportive in regards to the consumer performing the task?

5. Is the consumer seeing progress or is s/he facing a series of disappointments?

6. Is there so much change in the consumer's life that goal attainment is becoming overwhelming or stressful?

Discussion with the consumer will usually result in a clearer understanding of the barrier(s) to attainment. The supervision group could be involved in discussing the barrier(s) and generating alternatives for changing the steps toward attainment of the goal.

New Goals

After achievement of goals, with the consumer, determine new goals and follow the same steps toward achievement. This step does not require further elaboration except to note that as the consumer and case manager move on to new sets of goals, it is important for the case manager to continue to monitor the status of the consumer-resource linkages that have already been established. The ongoing performance of the consumer and the resource should be reviewed periodically by the case manager and the supervision group in order to direct immediate attention to any problems or barriers that may begin to appear. (University of Kansas, 1985)

Tracking and Evaluation

It is important that the case manager continuously track the status of all goals and evaluate if the desired goals were achieved and that no new problems have arisen because of the goal attainment process. Often, when consumers move to a different status because of the accomplishment of one goal, problems with adjustment to this status can occur. For example, if a consumer has secured employment, the stress and circumstances (new expectations) need to be monitored as to potential difficulties which may be created in the consumer's life. Review and evaluate the status (needs, community linkage, living situation, medication use, etc.) of each ongoing case at least on a quarterly basis. (University of Kansas, 1985)

Monitoring

Case management is a fluid activity; case managers are community bound, not office based. To monitor service delivery, the case manager must actively watch, listen and interact with both the consumer and all the service providers. Monitoring must occur while the consumer is participating in services and programs. Monitoring involves being with the consumer in his/her natural surroundings as well as the treatment environments. Therefore the case manager might be at one of many locations – the consumer's home, any office of a service provider, a restaurant in the consumer's neighborhood or a clubhouse, to name a few. Case managers often receive the most current and reliable information if they make first-hand observations. Also, to be effective, case managers must develop solid working relationships with both consumers and service providers.

Monitoring serves four global purposes (Moxley, 1989):

1. Ensure service coordination - At its best, it reviews programs and services not only for accountability, but also to see if everyone is addressing the same purposes stated in the Service Plan. Otherwise, the consumer may be exposed to discontinuous and/or conflicting interventions.

2. Determine achievement of the goals/objectives in the consumer's Service Plan - Through monitoring, the case manager can determine whether goals are being achieved, whether

they are being met according to the plan's projected timeline(s), whether goals continue to fit the needs of the consumer, or whether there is a failure to achieve stated goals.

3. Determines service and support outcomes - Ongoing observations can trigger reconsideration of the plan and its recommended interventions when the Service Plan is not accomplishing its desired effects.

4. Identify the emergence of new needs - Monitoring enables the CM to stay in touch with the consumer. Monitoring provides consistent help to the consumer in identifying problems, modifying plans, ensuring the consumer has resources to complete goals, and tracking emerging needs.

When the case manager is monitoring a consumer's progress towards meeting the service plan goals, he or she will be attempting to answer these questions:

1. Is the consumer getting the services established by the service plan?
2. Are the services provided in such a way that the consumer can benefit from them?
3. Are the services provided to the consumer meeting the objectives of the service plan?
4. Are the services provided in a manner that is beneficial or usable to the consumer?
5. Are the plans objectives appropriate to the consumer's current needs, skills, and abilities?
6. Will meeting the plan's objectives give the consumer the ability to continue living in the community?
7. Does the consumer need additional services or intervention to be able to continue making progress?

The questions point to the effectiveness of the services and the appropriateness of the service plan. The answer to the questions will lead to the next action. And if the current service plan is not helping the consumer, a revised assessment and service plan may be in order.

Personal Money Management

Often a crucial area of case management is helping the consumer budget his or her financial resources. Living independently means new financial responsibilities that require self-discipline and saving for long-term purchases. Some suggestions to help case managers with budgeting are:

- Work with the consumers to develop a list of priorities by helping them distinguish between needs and wants. Help them understand that money for the wants should come after the needs are taken care of.

- Do not push your judgments or values about money on to the consumer.

- Be careful to not "rescue." Work with the consumer to outline possible consequences (both positive and negative) for financial decisions.

- Do not use budgeting as a means of manipulation or punishment.

- Be aware of ethical concerns when dealing with consumers on financial issues and consult with your supervisor.

Some consumers will require a protective payee to manage their money. You, as the case manger, may be assigned this responsibility. Here are some additional guidelines if this is the situation:

- Continuously review the need for a Representative Payee. Remember that a basic value of case management is to help consumers be independent and gain more control over their own affairs. Encourage them to manage their own money as soon as possible.

- Know your agency policies and procedures about Representative Payees.

- Know the rules and regulations from Social Security about Representative Payees.

- Make sure to plan for holidays and vacations of staff. Consumers should be able to receive their payments in spite of staff absences or agency closings.

Transportation

While providing case management services, you will frequently have consumers in your (or the agency's) vehicle. Some points to keep in mind are:

- If you are able to drive personal vehicles for case management, check with your agency and your own personal insurance company to ensure proper coverage.

- Know and follow your agency policies about transporting consumers. Discuss these policies with your supervisor.

- Do not transport consumers alone whom you believe are a safety concern.

Advocating for Consumers

In the role of an advocate, the case manager attempts to bring about solutions to problems impeding the consumer's progress or infringing on his/her rights. The case manager also teaches the consumer to be a strong self-advocate.

Additionally, the case manager develops a network of community collaborators for advocacy. Community collaborators are resourceful, caring, and responsible individuals who are committed to the growth and development of the consumer. Often these collaborators

are family members, friends, neighbors, and community agency personnel. By meeting regularly with the consumer and with collaborators, barriers to consumer progress can be identified and steps can be taken.

Advocacy takes place at different levels of the service system. For example, the case manager may go with the consumer to reapply or submit an appeal for financial assistance, or a case manager may approach a public housing authority about developing low-income housing in rural areas. Advocacy is important. Through the process of case management, positive and long-term improvements for the consumers can be made.

Grievance Procedures

Grievance procedures refer to accepted administrative methods of solving problems or registering complaints. Mental health institutions and agencies should have grievance procedures clearly stated and have them publicly posted.

Any consumer has the right to know what these procedures are and to utilize them without fear of punishment. As a case manager, you may assist a consumer in using the grievance procedures of an agency. In Kentucky, all fourteen regional MHMR Boards have a consumer grievance procedure clearly written and posted at each site. Consumers have the right to have the grievance procedure explained in language they can understand, a right to ask for help in filing the grievance, and a right to make the complaint to someone other than their primary therapist.

If the consumer is dissatisfied with the outcome of the grievance procedure, they have the right to appeal using their Regional MHMR Board's internal appeal process. Finally, if the consumer is not satisfied with the final decision of the MHMR Board's internal appeal, a grievance may be filed with the Cabinet for Health and Family Service's Ombudsman at 1-800-372-2973 or 1-800-627-4702 (TTY).

Consumer Burnout

The notion of "consumer burnout" is an important issue. As professionals, we see it all the time as it relates to "no shows," "medication non-compliance," and the "treatment drop-out" rates for our established programs. It is unrealistic to expect that consumers would want to participate in treatment interventions unless they see signs of progress or understand how a specific activity relates to their current life situation. Consumers with SMI may be particularly susceptible to this phenomena given the long history of treatment that many have experienced, the multiple "helpers" encountered, and the fact that they may feel no better off now compared to when they started their journey.

Incorporating a small step, goal oriented approach into our intervention strategies can instill the hope for change and create a partnership for this change to occur. It is important to establish some measurable goals which can be accomplished relatively quickly and to emphasize the progress made. Think how satisfying it is to cross something off a list. Identify ways that you can share that satisfaction with the consumer who has the most to gain from each achievement.

Closure

Termination of case management can occur when the consumer no longer wants to receive case management services or when the case has been successfully completed. In order to determine if a particular case is ready for closure, the following points need to be assessed:

- Has the consumer acquired the needed resources and skills? Are any other resources or skills needed to maintain the consumer in the community?

- How long a period of stability has the consumer experienced in the community? In assessing this question, it is essential to review (through case records) the cyclical nature of the consumer's history. Consumers may experience distress around specific dates, stressors or issues in their life.

- Have you monitored the consumer's use of resources to insure that the relationships between the consumer and resources are secure and stable? How are problems resolved and have any new problems arisen?

- Have sufficient community supports been established to maintain the consumer-resource relationship? This could include using the family, neighbors and friends to provide supports and a telephone number of someone who can provide "on-call" assistance to the consumer in times of crisis.

- Has the consumer learned how to acquire resources to meet their goals? It may also include teaching the consumer how to set personal goals, break them into smaller steps, generate alternative resources, and how to approach the resource controllers.

Case managers must keep these five criteria clearly in mind while they plan and implement case closure. In a sense, the process of closure begins when a case is first received. The ending of a personalized relationship is difficult. Take time to process the closure issues that do arise. Remember that this can be an emotional time for both the case manager and consumer - use supervision (University of Kansas, 1985).

UNIT 7: ETHICS & RIGHTS

Description:

This unit will outline the importance of the case manager – consumer relationship including the elements of relationship, boundary issues, and NACM ethical guidelines. This unit will also introduce consumer rights and discuss confidentiality issues and principles.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Understand the concept of multiculturalism and the need for culturally competent practice.

2. Discuss boundary issues and NACM ethical guidelines.

3. Describe general consumer rights issues.

4. Explain confidentiality issues and principles.

SECTION 1: ETHICS & BOUNDARIES

Multiculturalism

The multicultural principles adopted by the International Association of Psychosocial Rehabilitation Services (IAPSRS) provide a framework for understanding the interaction of culture and mental health, as well as the practitioner's responsibility to continually strive toward a multicultural practice.

The following are the key concepts of multiculturalism:

- Multiculturalism is the study of one's own culture and ethnicity as the basis for the understanding and identifying with those of others
- Everyone has a culture, not just those whom we think of as minorities
- Everyone has an ethnicity, therefore every human encounter is a cross cultural encounter
- Our society is viewed as a mosaic rather than a melting pot
- All behavior occurs within a cultural context and we apply our own "cultural lens" to view the behavior of others
- Multiculturalism denotes the full inclusion of the individual with his or her culture and differences
- Multicultural professionals are students of their own ethnicities and cultures, and are aware of their own and other's biases, stereotypes and prejudices

The challenge is to respond to differences rather than to minimize them. The reality is that each of us has grown up in an encapsulated environment that has provided our value base, ethnic base, perceptions of family, and what is viewed as being right or wrong. Thus, in approaching others who may be different, many operate from their own ethnocentric perspective, which they treat as the only correct one. The reality is that one's own way is not always the right way for all people. It may mean that after developing self-awareness, one will have to change the way one works with differences so as to be effective in rendering relevant services that are culturally respectful of consumers.

Eleven Principles of Multiculturalism (IAPSRS, 1996)

Principle One: Practitioners accept that every individual has an ethnicity, as well as a gender, sexual orientation, level of ability/disability, age and socioeconomic status; therefore, they view every human encounter as a cross-cultural encounter.

Principle Two: Practitioners study, understand, accept, and appreciate their own cultures as a basis for relating to the cultures of others.

Principle Three: Practitioners recognize that differences, discrimination, and isolation continue to create unique situations in which culture may emerge. The cultures of gender, disability, or sexual orientation may also provide support, security, a sense of belonging and identity, similar to the cultures of ethnic heritage. The conditions of stigmatization, rejection, and discrimination are addressed as rights violations as well as barriers to the attainment of health.

Principle Four: Practitioners recognize that thought patterns and our behaviors are influenced by one's world view, of which there are many. Each world view is valid and influences how consumers perceive and define problems, perceive and judge the nature of help given and solutions developed.

Principle Five: Professionals show respect towards consumers by accepting cultural preferences which value process or product, as well as harmony or achievement, within one's life. Practitioners also demonstrate respect by appreciating cultural preferences, which value relationships and interdependence, in addition to individuation and independence.

Principle Six: Practitioners accept that the solution of problems is to be sought within consumers, their families, and their cultures. Alternatives identified by practitioners are to be offered as supplementary or educational.

Principle Seven: Practitioners apply the strengths/wellness approach to all cultures.

Principle Eight: Interventions are culturally syntonic (in emotional equilibrium and responsive to the environment) and accommodate culturally determined needs, beliefs, and behaviors. Modalities are modified in order to be compatible with family/group patterns and structures; communication, cognitive, behavioral, and learning styles; identity development; perceptions of illness; and help-seeking behaviors.

Principle Nine: Practitioners recognize that discrimination and oppression exists within our society; these take many forms, including race, ethnicity, gender, sexual orientation, class, disability, age, and religious discrimination/oppression. Practitioners have a role and responsibility in mitigating the effects of these "isms," advocating not only for access to the opportunity and resource structure, but for the elimination of all "isms."

Principle Ten: Practitioners are responsible for actively promoting positive inter-group relations, particularly between the consumers in their programs and the larger community.

Principle Eleven: Practitioners engage in ongoing cultural competence training in order to increase their knowledge and skills of appropriate effective cross-cultural interventions. Practitioners are committed to learning about problems and issues that adversely and disproportionately affect the various cultural groups with whom they work.

Boundary Issues and Ethical Guidelines

Case managers need to be conscientious about providing services within local, state and federal laws, as well as general ethical practices. Issues of concern may include substance abuse, confidentiality, dual relationships, setting and maintaining appropriate boundaries, and imposing values. As case managers, you will be faced with boundary and ethics issues on a daily basis. The following information is designed to assist you in making critical decisions concerning these issues. There are not any definitive measures or directives, but there are guidelines and strategies that will facilitate daily practice.

The boundaries established by staff are based on many factors, including: board policies, program/service expectations, past experiences, and personal comfort. Most limits and boundaries are maintained by sound judgment of the case manager.

There are a variety of ways to define a boundary. What is important in the helping relationship is that:

- You know your own boundaries and are honest about them; and
- You respect those of the consumers with whom you work.

What should you do when faced with a situation where boundary issues may be a concern? Ask yourself:

- What is my intended action?
- What is my intended effect on the consumer?
- What are other possible effects on the consumer, positive and negative?
- What promises might this action imply? (Could this be misunderstood?)
- Does this action change any roles?
- For whom am I doing this; whose needs am I meeting?
- Are there other ways or actions to reach my intended goal?

Case managers must never under any circumstances, date or in any way encourage intimacy with consumers. They should not routinely receive phone calls at their homes or otherwise indirectly suggest that the professional relationship may become a personal one. Supervisors and other staff members should be used to help the case manager answer specific questions about this.

Case managers who were previously, or may still be consumers, may have special problems in clarifying which role is appropriate. The consumer case manager can have special understanding and sympathy for the problems of consumers, but that very strength might sometimes result in conflicting loyalties and misunderstandings. The consumer case manager needs to discuss these problems with his/her supervisor and know the specific expectations of the agency.

The following ethical guidelines by the National Association of Case Management (NACM) should be studied and understood by each case manager:

As a Case Manager, I:

- √ Am committed to respect the dignity and autonomy of all persons and to behave in a manner that communicates this respect.
- √ Am committed to each individual's right to self-determination, and the rights of people to make their own life choices, and I am committed to embarking hopefully on a recovery journey with every person I serve, letting them direct their own healing process.
- √ Am committed to fight stigma wherever I find it, to educate the community, and to promote community integration for the people I serve.
- √ Do not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, creed, gender or sexual orientation.
- √ Strive to both seek and provide culturally sensitive services for each person and to continually increase my cultural competence.
- √ Am committed to helping persons find or acknowledge their strengths and to use these strengths in their journey of recovery.
- √ Am committed to helping persons achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills and competencies.
- √ Acknowledge the power of self-help and peer support and encourage participation in these activities with those I serve.
- √ Am honest with myself, my colleagues, the people I serve, and others involved in their care.
- √ Keep confidential all information entrusted to me by those I serve except when to do so puts the person or others at grave risk. I am obligated to explain the limits of confidentiality to the persons I serve at the beginning of our working together.
- √ Am committed to a holistic perspective, seeing each person I serve in the context of their family, friends, other significant people in their lives, their community, and their culture, and working within the context of this natural support system.
- √ Must strive to maintain healthy relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.
- √ Maintain a commitment to prevent crisis situations with the people I serve, to present and support crisis alternatives, to develop an advanced instruction crisis plan with the individual whenever possible, and to avoid forced treatment unless there is a clear and present danger to the person served or another.
- √ Have an obligation to consult with my supervisor, obtain training, or refer to a more qualified case manager any individual with a need I do not feel capable of addressing.
- √ Have an obligation to remain curious; learning, growing, developing, and using opportunities for continuing education in my field or profession.
- √ Am committed to a regular assessment of my service recipients' expectations of me and to consistently improving my practice to meet their expectations.
- √ Have an obligation to advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs.

SECTION 2: CONSUMER RIGHTS

Consumers in state-operated and private facilities and agencies have certain rights, including the right to dignity, privacy, humane care, and freedom from abuse. They also have the right to treatment, the right to be informed of risks and benefits of treatment, the right to an individualized treatment plan, and the right to be free from unnecessary or excessive medication. Consumers have the right to refuse medication during involuntary inpatient or outpatient commitment or voluntary inpatient commitment. However, in certain circumstances--and following prescribed procedures--consumers may be given medications against their wishes in an inpatient setting.

It is imperative for case managers to understand the rights of consumers, laws established concerning consumer rights, and agency policies and procedures regarding consumer rights and responsibilities. These should be discussed in supervision.

The Kentucky Department for Medicaid Services identifies five basic consumer rights in the Targeted Case Management Services Adults Manual:

1) Consumers shall have freedom of choice of case management services.
2) Consumers shall have freedom of choice of participating case management providers.
3) Consumers shall have freedom of choice of case managers employed by the case management provider.
4) Consumers shall be allowed to have free choice of service providers of any other Medicaid-covered services.
5) Consumers shall be involved in the development of their treatment plans.

Assurance of Case Management Services Certification Form (MAP-586) shall be signed by the consumer and placed in the consumer's record.

Confidentiality

Confidentiality is very important to the case manager-consumer relationship. Case managers must be informed about confidentiality laws, and agency policies and procedures regarding the disclosure of information.

What is confidential information? It is any information related to an individual served by an agency or facility that was received while the agency or facility was providing any function for the person. Confidentiality is both a consumers' rights issue and a professional ethics issue. It is a necessary ingredient in the case manager-consumer relationship.

There may be instances when it is helpful to share consumer information with others who provide assistance to the consumer, including family and friends. To prevent any problems with sharing information when it is necessary, the case manager and the consumer must consider situations that may warrant this and appropriately plan for them.

Although maintaining confidentiality is a necessary ingredient for the case manager-consumer relationship, open and honest communication to the consumer about the limitations of complete confidentiality is critical. There are a variety of situations where it is ethical and legal to compromise confidentiality. Therefore, confidentiality is not an absolute. Exceptions to the confidentiality rule are as follows:

- Consumer is a danger to him/herself and/or others;
- Abuse, neglect, or exploitation of children or adults;
- It is necessary to honor the duty to warn laws; and
- Third party payer sources request access to consumer records.

Case managers must be careful to not share unnecessary information with others about the consumer in their efforts to provide assistance and access resources. Consumer rights and confidentiality must be respected at all times. Case managers should always consult with supervisors regarding confidentiality questions or issues.

UNIT 8: RESOURCES

Description:

This unit describes the crucial task of linking individuals with the resources they need to successfully implement their Service Plan. This unit also provides information about essential community resources and entitlements.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Identify case management roles.
2. Identify local and state resources.
3. Identify housing resources
4. Describe the difference between Project-Based Rental Assistance and Tenant-Based Rental Assistance.

SECTION 1: ACQUIRING & MANAGING

The purpose of resource acquisition is to acquire the environmental resources desired by consumers to achieve their goals, insure their rights, and to increase each person's assets.

A primary focus is to break down the walls separating consumers from the community and to replace segregation with true community integration. To be successful, it is the responsibility of each case manager to learn the resources in their community that are beneficial to their consumers and to assist consumers in accessing and utilizing these community resources. Case managers must also be familiar with the key contact persons within particular agencies.

Some websites of interest:

CMHC locator

Substance Abuse Treatment Directory

Dept. for Health and Human Services - Current poverty guidelines

Case Management Roles in Resources Acquisition

Implementer: It is not unusual for case managers to directly intervene with consumers who may be experiencing extremely disruptive life events and who may be somewhat immobilized as a consequence. Loss of housing, the death or departure of a significant other, or loss of income frequently precipitate temporary or episodic crisis.

Instructor: This role may involve staff working directly with consumers in developing skills which will enable them to become their own case managers so that they can subsequently fulfill their own needs. Teaching can include a variety of learning experiences including: review of interpersonal skills and techniques related to locating a place to live or employment, making friends, or negotiating benefits at a social service or entitlement program. This can be accomplished through direct suggestions, role playing and modeling.

Guide: In this role, the case manager works with the individual to identify the resources or entitlements that the consumer requires to fulfill their needs and then guides the individual through the process of resource acquisition. This can include providing information and helping the consumer to exercise problem-solving skills, modeling ways to work with providers or program representatives, and staying with the consumer during the negotiation process to offer support and the possibility of later performance feedback.

Information specialist: Case managers can facilitate resource acquisition by helping consumers gain access to the specialized knowledge of human services, benefits systems, and other

opportunities. In this role, the CM helps the consumer problem-solve and makes available their knowledge of community resources, appeals processes, and contact persons. The implementations of these functions are less intrusive than some of the roles earlier described.

Identifying and Developing Community Resources

Income:

The Social Security Administration provides income from two separate programs:

- Supplementary Security Income (SSI) - This is a federal benefits program for the needy, aged, blind, and disabled. Eligibility is based upon medical documentation of a disabling physical or mental illness together with financial need. A thorough medical assessment and diagnosis with laboratory findings and other supporting evidence is required to support a successful application. It is in the consumer's best interest to appeal any findings of ineligibility, particularly at the first step. Entitlements are retroactive to the original date of application.

- Social Security Disability Insurance (SSDI) - This is a federally funded insurance program for the blind and disabled, funded by deductions from the applicant's payroll wages. Eligibility is based upon medical documentation of a disabling physical or mental illness. As with other insurance programs, a person must have contributed to it to receive payments later.

Other income sources are:

- Kentucky Transitional Assistance Program (K-TAP) – **(K-TAP)** is the monetary assistance program established by Kentucky using federal funds from the Temporary Assistance for Needy Families (TANF) block grant. K-TAP is available for families with dependent children who meet certain technical and financial criteria. In addition to the monetary grant, K-TAP recipients may also be eligible for supportive services such as childcare and transportation assistance through the Kentucky Works program.

- Veterans Administration **Benefits** – VA benefits are available to veterans who have served in the US armed forces and who have received a discharge under other than dishonorable conditions. Dependents also may be eligible. The VA compensates veterans who are disabled by injury or disease that occurred or was aggravated during active service. Pension benefits are payable, based on need, to veterans permanently and totally disabled or over 65 who are discharged after 90 or more days of service. Consumers may apply for benefits at the nearest VA office.

Medical Insurance

- **Medicare –** A federally funded health insurance program that is administered by the Social Security Administration. Individuals who are 65 or older and those that receive SSDI benefits are automatically eligible for Medicare after they have received SSDI checks for twenty-four months.

- Medicaid - A federal program to help low-income citizens with disabilities obtain medical care. It is administered by the Department for Community Based Services. Consumers who qualify for SSI also qualify for Medicaid.

Medical Care

- Local health departments provide services that vary among counties.

- Some private doctors and dentists do not accept payment through Medicaid, so you will need to become familiar with the providers in your area who accept this insurance.

- Local free clinics – Healthcare for the Homeless programs

Food

Food Stamps – This program is administered by the Department for Community Based Services (DCBS). Eligibility and amount of assistance is determined by income. Food stamps are now distributed as the EBT Card. In emergency situations, they can be authorized and obtained within several days of application.

WIC - Local health departments administer the federal WIC program, which provides certain foods to pregnant **women, infants, and children** at risk of malnutrition. These foods are purchased by consumers at cooperating grocery stores using a voucher system.

Food Bank - From time to time, the federal government offers free foods through the Department of Agriculture. Typical items are flour, butter, and cheese.

The Salvation Army provides limited amounts of money for food.

Soup kitchens in larger communities provide free meals.

Employment

Department of Vocational Rehabilitation - provides evaluation, money for training, other necessary supports, and assists in locating suitable employment.

Sheltered workshops are available in many areas and designed to meet the needs of people with mental retardation. Although these workshops are often not suitable for most people with severe and persistent mental illness, workshops may be a good choice in a few cases.

Other

Your local **Department for Community Based Services** will have information on various resources that are available locally and statewide.
This may include information on access to such resources as food, medical and dental care, clothing, financial assistance with utility and phone bills, etc.

Your local **Community Action Agency** will have information on assistance with utility bills, food and clothing, housing, and other financial aid.

Another good source of charitable assistance is your local **Ministerial Association** or local church.

Other case managers and staff in your organization may also have information on available resources. Get to know them and the persons in the community that control access to the resources above. Get to know the doctors, dentists, pharmacists, landlords, employers, and persons in local government. Build a network of potential contacts for future needs.

SECTION 2: HOUSING

The affordability standard for housing is considered to be 30% of household income. That means that a person / household should pay no more than 30% of monthly income for rent. Since many of the persons you will be assisting receive SSI or are employed in low-wage jobs, finding affordable housing can be quite difficult.

The Department for Housing and Urban Development (HUD) determines Fair-Market-Rent for each county in each state. In none of the states are there any counties in which a person on SSI can afford fair-market-rent.

Two methods of housing assistance make up the difference:

- Project-Based Rental Assistance
- Tenant-Based Rental Assistance

Project-Based Rental Assistance

These include the local Housing Authorities located in each county, and other subsidized, low-income housing developments. A person living in one of these housing units will pay approximately 30% of monthly income for rent. (There are adjustments for what income is counted and for allowable deductions) Funding for the subsidy for these housing units comes from HUD. This assistance is available as long as the person remains in the rental unit. In other words, the assistance goes with the apartment, not with the person. If the person moves out of the unit, this assistance is lost. For more information on this program, and a list of local Housing Authorities and Subsidized Apartments, visit the HUD website.

- If a person moves out of one of these units, they may be transferred to Tenant-Based Rental Assistance.

Section 811 Supportive Housing for Persons with Disabilities.

HUD also provides funding through this program to nonprofit organizations to develop rental housing with the availability of supportive services for persons with disabilities. The tenant will again pay approximately 30% of monthly income for rent, and supportive services are available but are not required as a condition of occupancy. The purpose of this program is to allow persons with a disability to live as independently as possible in the community.

Your Regional MHMR Board may have developed housing with this assistance in your area.

1-5. Resident Eligibility

A. Eligibility for Occupancy (General)

Occupancy of Section 811 housing is open to persons with disabilities. A person with a disability is a household composed of one or more persons, at least one of whom meets the following criteria:

1. is at least 18 years of age or older; and,
2. has a physical, mental or emotional impairment which:
   a. is expected to be of long-continued and indefinite duration,
   b. substantially impedes the person's ability to live independently, and
   c. is of a nature that such ability could be improved by more suitable housing conditions. OR
3. has a developmental disability, defined as a severe chronic disability which:
   a. is attributable to a mental or physical impairment or combination of mental and physical impairments,
   b. is manifested before the person attains age twenty-two,
   c. is likely to continue indefinitely,
   d. results in substantial functional limitation in three or more of the following areas of major life activity:
      (1) self-care,
      (2) receptive and expressive language,
      (3) learning,
      (4) mobility,
      (5) self-direction,
      (6) capacity for independent living, and
      (7) economic self-sufficiency.
   e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong, or extended duration and are individually planned and coordinated.

B. Disability Categories

For the purposes of the Section 811 program, disabilities are separated into three major categories:

Physical disability (meeting the criteria in 2. above),
Developmental disability (meeting the criteria in 3. above),
Chronic mental illness (meeting the criteria in 2. above).

C. Eligibility of Alcoholics, Drug Addicts and Persons with the Human Acquired Immunodeficiency Virus (HIV).

A person whose sole impairment is alcoholism, drug addiction or an HIV-positive diagnosis (i.e., who does not have a physical disability, developmental disability or chronic mental illness which is the disabling condition required for eligibility in a particular project) is not considered disabled under the Section 811 program and is, therefore, not eligible for occupancy in any Section 811 project.

D. Eligibility of Households with a Disabled Child.

As described above, eligibility for occupancy is contingent upon one member of the household being at least 18 years of age and disabled. Thus, in order for a household that has a child with a disability to qualify for occupancy in Section 811 housing, the child must be at least 18 years old or an adult (age 18 or older) in the household must have a disability meeting one or more of the criteria above.

E. Restriction of Occupancy to Persons Having Similar Disabilities.

With HUD Headquarters approval, Owners may restrict occupancy of Section 811 projects to persons who have similar disabilities (i.e., subcategories of the three major disability categories described in paragraph B. above) if they can justify that the proposed occupants share a need for a similar set of supportive services that are unique to their disability.

1-7. Project Eligibility

A. Types of Housing.

The following types of housing are eligible to be developed under the Section 811 program:

1. Group home. A single family residential structure that may combine multiple bedrooms (single or double occupancy) with a kitchen, shared living areas, utility areas and at least one bathroom for every four (4) persons, all of which are known as common areas. A one-bedroom unit may be provided for residential staff.
2. Independent living facility. A project consisting of separate units where each dwelling unit includes a kitchen and a bath. The structure may contain a congregate dining facility, community space, a laundry, small administrative office and storage. A one-bedroom unit may be provided for residential staff.
3. Intermediate care facility. A group home for persons with developmental disabilities that is licensed by the State Medicaid Agency and receives Title XIX funds to cover the cost of services. In order to qualify as an intermediate care facility, the project must meet the following criteria:
   a. The proposed project will be a housing facility rather than be medical in nature.
   b. Necessary medical services will be provided off-site.
   c. The design of the facility must not include medical features. (e.g., nursing stations, oxygen outlets, lavatories in bedrooms, call buttons in bedrooms).

d. The in-house staff are not medical professionals.
e. The residents will be enrolled in structured programs outside the home for at least six hours each weekday.
f. The State Agency (e.g., Medicaid) accepts responsibility to pay the tenant contribution to rent in the Medicaid payment to the Owner.

4. Cooperative/Condominium Projects. An independent living facility can be developed for cooperative ownership by the residents. A Sponsor can also purchase units in an existing condominium, provided the condominium documents do not conflict with the HUD Regulatory Agreement.

1-9. Supportive Services.

A. General.

While adequate housing is a basic necessity of life for everyone, the provision of housing alone cannot create a stable living environment for many persons with disabilities. Housing is one component in the spectrum of services needed for persons with disabilities to live independently in the community. Thus, the provision of supportive services is essential to the success of any Section 811 project. It is the responsibility of the Sponsor to arrange for the provision and funding of those services appropriate to the assessed needs of the residents. For some residents with physical disabilities, for example, services may be limited to housekeeping assistance, personal care attendants, or structured recreational or educational activities. Other residents with more severe physical or mental disabilities may require more intensive services such as case management, training in the skills of independent living (i.e., personal grooming, cooking, money management, etc.), medication monitoring, occupational therapy, or training in social skills. Necessary supportive services should be provided off-site to the greatest extent possible to ensure a normal (non-institutional) home environment for the residents.

B. On-site services may include the following:

1. case management
2. personal assistance/attendant care
3. housekeeping assistance
4. supervision
5. counseling/advocacy/referral
6. training in independent living skills
7. recreation
8. transportation
9. meals and nutrition

C. Off-site services may include the following:

1. health and dental care (Health care must be based in the community, not in the project. No on-site staff provisions may be made for doctors, nurses or other medical personnel.)
2. periodic inter-disciplinary diagnostic and assessment services
3. specialized educational/vocational services

Tenant-Based Rental Assistance

This assistance is similar to the Project-Based Rental Assistance in that the tenant will pay approximately 30% of monthly income for rent. The difference is that this assistance goes with the tenant not the apartment.

A person receiving this assistance will then locate a landlord within the community that will accept this assistance. The unit must then pass a Housing Quality Standard inspection. If after one year a person wants to move to another rental unit, within program guidelines, that person can take the assistance with them to the new unit.

This assistance is more commonly known as Section 8 or the Housing Choice Voucher Program, and is administered in some areas by the local Housing Authority. In all other areas, it is administered by the **Kentucky Housing Corporation** (KHC).

More information can be found on this program on the HUD website.

KHC also administers other programs which may be of assistance.

HOME TBRA - These funds may be used to help pay the cost of monthly rent and utilities, and to pay security deposits. It is similar to the Housing Choice Voucher (Section 8) in that the tenant will pay approximately 30% of income, however, this assistance is temporary. It is hoped that the tenant can then be transitioned to the Housing Choice Voucher. Your Regional MHMR Board may have access to this assistance; other non-profits, local governments, and private developers can apply for this as well.

Safe Place - This program offers temporary assistance to persons with serious and persistent mental illness who are leaving shelters or marginal housing situations. A critical component of this program is the case management, services and supports provided by the local Regional MHMR Board. Persons in this program are then transitioned into permanent housing assistance that has set-asides for persons with a mental illness.

Homeless Assistance

KHC also administers other programs through the HUD Continuum of Care process which may be of assistance.

Shelter + Care - This program is designed to link rental assistance to supportive services for hard-to-serve homeless persons with disabilities and their families.

Supportive Housing Program - This program is designed to promote the development of supportive housing and supportive services for homeless persons and includes the development or expansion of permanent housing facilities for homeless, disabled persons.

Regional MHMR Boards

Although housing cannot be the main mission of the Regional Boards, they have seen that there is insufficient housing available and continue to address that need. The Regional Boards use a variety of strategies to develop housing options for persons with severe and persistent mental illness. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs (TBRA, Safe Place) or through collaborative arrangements with local public housing agencies. Regional Boards currently operate over 500 units in 47 projects, and have access to 500 Safe Place Vouchers statewide, in addition to TBRA vouchers and Shelter + Care.

Regional Housing Programs

Region 1, Four Rivers Behavioral Health - *Ph: 270-247-8735*
Fuller Apartments, Graves County, 12 Units

Region 2, Pennyroyal - *Ph: 270-886-5163*
KARP Duplex, Hopkinsville, 2 Units, KARP Duplex, Princeton, 2 Units

Region 3, River Valley - *Ph: 270-683-0438*
Apartments, Owensboro, 12 Units, Apartments, Henderson, 20 Units

Region 4, LifeSkills - *Ph: 270-901-5000*
Apartments, Bowling Green, 3 Units

Region 5, Communicare - *Ph: 270-769-1304*
Countryside Apartments, Elizabethtown, 15 Units, Ashberry Terrace, Bardstown, 10 Units

Region 6, Seven Counties Services - *Ph: 502-635-1570*
Wellspring Apartments, Louisville, 54 Units, Wellspring Permanent, Louisville, 30 Beds, Wellspring Transitional, Louisville, 21 Beds, Jefferson St. Baptist, Louisville, 20 Beds, VOA Transitional, Louisville, 16 Beds

Region 7, NorthKey - *Ph: 859-431-1888*
Greenup Haus, Covington, 19 Units

Region 8, Comprehend - *Ph: 606-564-4016*
Stoneleigh Apartments, Maysville, 29 Units

Region 9/10, Pathways - *Ph: 606-324-1141*
Pollard Place, Ashland, 15 Units, Evergreen Square, Ashland, 15 Units, White Avenue House, Mt. Sterling, 3 Units, Ronameki house, Mt. Sterling, 4 Units
Region 11, Mountain - *Ph: 606-886-8572*
Hidden Valley, Paintsville, 2 Units

Region 12, Kentucky River - *Ph: 606-666-9006*
Sun Valley Apartments, Hindman, 16 Units, Townview Apartments, Jackson, 17 Units, Wolfe Apartments, Campton, 4 Units, Eilerman House, Booneville, 4 Units, Grapevine Apartments, Hazard, 4 Units, Marigold Apartments, Beattyville, 3 Units, Ivy Court Apartments, Jackson, 12 Units, Hilltop Apartments, Hazard, 1 Unit, Wolfe Emergency Apts., Campton, 2 Units, Primrose Circle, Campton, 12 Units

Region 13, Cumberland River - *Ph: 606-528-7010*
Phoenix House, Corbin, 15 Units, Transition House, Harlan, 8 Units, Sunshine Apartments, Corbin, 4 Units

Region 14, Adanta - Ph: 606-679-4782
McCreary Apartments, Stearns, 2 Units, Transitional Duplexes, Columbia, 4 Units

Region 15, Bluegrass - Ph: 859-253-1686
Franklin Place, Frankfort, 12 Units, Bivins Place, Richmond, 10 Units, Rall Place, Danville, 12 Units, Lincoln Place, Stanford, 4 Units, Supervised Apartments, Lexington, 7 Units

Other Housing Organizations - for persons with a mental illness

Wellspring, in Louisville, was founded in 1982 through a collaborative effort of parents, doctors, and civic leaders concerned about the needs of persons with psychiatric disabilities. Wellspring has developed 6 staffed residences and 14 community-based independent housing sites, including a Crisis Stabilization Unit, Transitional Housing, Supported Housing, and Independent Housing.

New Beginnings, Bluegrass, in Lexington, modeled after the Wellspring program in Louisville, provides a variety of permanent housing options, including independent living, shared housing and supervised group home living. Supportive services are also provided according to the level of need.

UNIT 9: SUICIDE RISK ASSESSMENT

Description:

This unit discusses the demographics and risk factors of suicide, describes suicide risk assessment techniques, and a practical approach to assessing and managing suicide risk in depressed patients.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Describe the demographics and risk factors of suicide.

2. Identify suicide risk assessment techniques.

3. Describe approaches to assessing and managing suicide risk.

Individuals with severe mental illness are at increased risk for suicide. It is important that case managers have knowledge about factors that contribute to suicide risk, and are comfortable talking with consumers about possible thoughts of suicide and planning to carry out suicidal acts.

The following is an article that, while written for primary care physicians, gives a good overview of suicide risk assessment.

Principles of suicide risk assessment

How to interview depressed patients and tailor treatment

Richard L. Frierson, MD; Margaret Melikian, DO; Peggy C. Wadman, MD

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Preview: Suicide is a significant cause of death in the United States. Because many patients who commit suicide visit their primary care physician in the weeks before their death, physicians need to be familiar with suicide risk assessment techniques. In this article, Drs Frierson, Melikian, and Wadman discuss the demographics and risk factors of suicide and propose a methodical, practical approach to assessing and managing suicide risk in depressed patients. *Frierson RL, Melikian M, Wadman PC. Principles of suicide risk assessment. Postgrad Med 2002;112(3):65-71*

Suicide is the eighth leading cause of death in the United States (1). In 2002, more than 30,000 people will commit suicide in this country, the equivalent of more than 80 suicides a day or one every 20 minutes. Self-directed violence will result in more than 600,000 emergency department visits.

In 1999, in response to alarming statistics about suicide, US Surgeon General David Satcher issued a call to action, stating that "the nation must address suicide as a significant public health problem and put into place national strategies to prevent the loss of life and the suffering suicide causes" (2). This goal is enormous, and primary care physicians are crucial to achieving it.

Because primary care physicians are trained to diagnose and treat medical illness (including depression), they are accustomed to dealing with patients who seek help for problems and who desire to live rather than to die. A suicidal patient may evoke significant strong emotions in a physician, such as anger toward the patient or fear of losing the patient, of personal failure in preventing suicide, or of medicolegal consequences if the patient makes a serious or successful suicide attempt. However, despite these emotions, physicians have tremendous potential to respond to this call to action by arming themselves with the knowledge and skill to successfully treat depressed patients and prevent suicide.

The confidential and personal nature of the physician-patient relationship is unique. Patients often disclose information to their physicians that they would not disclose to even a spouse or family member. These disclosures may include feelings of hopelessness or despair or frank suicidal thoughts. Furthermore, patients who commit suicide are more likely to have established a treatment relationship with a primary care physician (3) and to have visited their physician in the days or weeks before the suicide (4); this is especially true of older patients (5). According to one study (6), 20% of older patients who committed suicide visited their primary care physician on the same day as their suicide, 40% within 1 week, and 70% within 1 month. These findings put primary care physicians on the front line in identifying depressed and suicidal patients and underscore the importance of suicide risk assessment in primary care.

A recent survey of physicians who lost a patient to suicide found that risk assessments had been completed in only 38% of cases (7). Another study (8) suggests that many primary care physicians have an age bias that makes them less likely to intervene or contemplate treating elderly suicidal patients. Also, adequate assessment and management of suicidal ideation become a time-consuming process that may significantly increase job stress for already stressed physicians (9). We may be

reluctant to ask what we do not want to hear. A patient's admission of suicidal ideation makes our jobs more difficult, and suicide risk assessment cannot be done quickly.

Through greater awareness of suicide risk assessment techniques, physicians may become more confident in dealing with depressed, suicidal patients. Understanding the demographic variables and risk factors of suicide attempts can facilitate assessment of suicide risk.

Demographics

The rate of suicide in the United States is 10.6 per 100,000. Ninety percent of people who commit suicide have a diagnosable mental disorder--commonly depression or substance abuse (10). In 1997, suicides outnumbered homicides by a 3:2 ratio. Suicides were twice as common as deaths due to HIV and AIDS. Firearm use is the most common method of committing suicide for both men and women and accounts for 58% of all suicides. Four times as many men as women die by suicide, but women are more likely to attempt suicide. White men commit 72% of all suicides (11).

Suicide is most common in elderly people and adolescents. The highest rate of suicide is in men older than 85, occurring at a rate of 65 per 100,000. Adults older than 65 account for 13% of the US population but 20% of suicide deaths. In persons aged 15 to 24, suicide is the third leading cause of death, occurring at a rate of 11.5 per 100,000.

Risk factors

Predicting suicide is difficult and inexact because suicide is a rare event. However, certain factors have been linked to increased suicide risk. The mnemonic SAD PERSONS, introduced by Patterson and colleagues (12), is a quick and useful risk assessment tool (see below). The most important variables in this scale are age (elderly or adolescent), alcohol dependence, and a history of suicide attempts, especially those that required lifesaving medical intervention. A history of serious suicide attempts may be the best single predictor of completed suicide (13); the greatest risk occurs within 3 months of the first attempt (14). The suicide rate among persons with alcohol dependence is 50 times that of persons without alcohol dependence (14).

Most persons who commit suicide have a diagnosed psychiatric disorder (15). Depression combined with social isolation and the recent loss of an intimate relationship dramatically increases risk (14). It is important for physicians to ask about suicidal ideation when a patient is suspected of having depression, because such patients usually give warnings of their intent. Expressions of hopelessness are a particularly ominous sign, and patients who admit to an organized plan of action are at maximum risk.

A high percentage of persons who commit suicide have coexisting personality problems, such as impulsivity and aggression. These traits lead to increased risk of self-harm, especially if substance abuse is present (16). Also, the relationship between physical illness and suicide is significant: postmortem studies demonstrate physical illness in up to 75% of persons who commit suicide (14). Finally, violent behavior, independent of alcohol or drug use, recently has been identified as a risk factor for suicide (17).

The risk assessment interview

Eliciting a depressed patient's suicidal thoughts requires the use of an open-ended, nonjudgmental interview style. The physician who asks a depressed patient, "You're not seriously considering suicide, are you?" has little chance of uncovering suicidal thoughts in a patient at significant risk. The topic of suicide can be approached by asking the patient about feelings of hopelessness and despair, such as "When you're feeling depressed, have you ever felt that there is no hope or that you will never feel better?" If the answer is yes, ask more direct questions about suicidal thoughts and intent. Patients who demonstrate active suicidal ideation or passive thoughts of suicide (eg, by saying "Life doesn't seem worth living") require a formal suicide risk assessment (table 1).

Table 1. Elements of a suicide risk assessment interview with a depressed patient

Current suicidal thoughts, intent, and plan
History of suicide attempts (eg, lethality of method, circumstances)
Family history of suicide
History of violence (eg, weapon use, circumstances)
Intensity of current depressive symptoms
Current treatment regimen and response
Recent life stressors (eg, marital separation, job loss)
Alcohol and drug use patterns
Psychotic symptoms
Current living situation (eg, social supports, availability of weapon)

Encouraging a patient to spontaneously elaborate on suicidal thoughts may reveal important clues that are useful in risk management. Begin with an empathic, open-ended request, such as "Tell me about those thoughts. How did you come to feel this way?" Follow up with more specific, closed-ended questions, such as "How long have you had these thoughts? Do you have a specific plan? Have you told anyone?" Also inquire about the patient's reasons for not having attempted suicide, because this may provide valuable information in formulating the treatment plan.

Obtaining a history of suicide attempts is crucial; information should include the circumstances in which attempts occurred, whether the patient sought help or treatment before an attempt, and the potential lethality of the method. The more serious the attempts, the higher the risk of a future attempt. Carefully explore the circumstances surrounding attempts, such as loss of a job or relationship. Because suicide is more common among first-degree relatives of suicide victims, ask about a patient's family history of suicide (18). Finally, inquire about previous weapon use and acts of violence, including the circumstances.

Review the patient's current depressive symptoms, giving special attention to feelings of hopelessness, helplessness, and excessive and inappropriate guilt. Listen for statements such as "My family would be better off without me." Inquire about the patient's current attitude toward treatment, including lack of response to medication as it relates to the symptom of hopelessness. In addition, asking about current psychosocial stressors (eg, job or relationship loss, onset of serious physical illness) may provide clues to the source of suicidal thoughts. If current stressors are similar to those that occurred before previous suicide attempts, the patient is at significantly increased risk.

Patients with altered perceptions of reality, such as those caused by intoxication or psychosis, are at increased risk of suicide. Given the link between suicide and alcohol dependence, it is important to obtain a complete history of alcohol and drug use. Note whether suicidal thoughts occur during intoxication or sobriety, or both. The presence of psychotic symptoms in a depressed patient with suicidal ideation is an ominous sign. Three types of psychotic symptoms are particularly worrisome and could push a patient to commit suicide: (1) auditory hallucinations commanding suicidal acts, (2) thoughts of external control (feeling that an outside force controls one's actions), and (3) religious preoccupation (9). Patients may not readily report these symptoms; collateral interviews with family members can help confirm psychosis.

Evaluation of the patient's environment is as important as evaluation of the patient. Inquire about social supports because they may be necessary in planning a safe clinical intervention. For example, a suicidal patient who lives alone may require

hospitalization, while a patient with identical risk factors who lives with family members might be safely treated as an outpatient. An assessment of the patient's access to firearms and other weapons is crucial. Family members can assist by removing weapons from the home until the patient's suicidal thoughts and depression subside.

Initial management and disposition

After assessing a patient's risk for suicide, physicians are faced with the important decision of how to best care for the patient. Although most patients with suicidal ideation can be treated as outpatients, others require hospitalization. It is useful to categorize depressed patients who are potentially suicidal into three groups: (1) patients with ideation, plan, and intent, (2) patients with ideation and plan but without intent, and (3) patients with ideation but no plan or intent.

The following recommendations may help physicians safely treat suicidal patients:

- Depressed patients with suicidal ideation, plan, and intent should be hospitalized, especially if they have current psychosocial stressors and access to lethal means. When a patient's life is in imminent danger, the physician may breach confidentiality and contact a family member. Depressed patients who refuse hospitalization may be involuntarily committed in most states if their suicidal thinking makes them a danger to themselves or others. Physicians can contact their local mental health center, crisis center, or emergency department for assistance in arranging such commitments.
- Depressed patients with suicidal ideation and a plan but without intent may be treated on an outpatient basis, especially when they have good social support and no access to lethal means. However, some of these patients need hospitalization, especially if their environment does not offer adequate safety measures, such as responsible supervision. Outpatient treatment may consist of antidepressant therapy (preferably with antidepressants that are safe in overdose), referral to a drug and alcohol treatment program, psychotherapy, or all of these. Patients whose depressive symptoms do not respond to treatment within 4 to 6 weeks should be referred to a psychiatrist.
- Depressed patients who express suicidal ideation but deny plan or intent should be evaluated carefully for psychosocial stressors. Physicians should encourage the patient or family members to remove weapons and other potentially lethal means from the patient's environment. In general, patients in this category may be safely treated with antidepressant medication on an outpatient basis, but they should be seen by their physician often as long as suicidal thoughts persist. If depressive symptoms do not improve within 4 to 6 weeks, psychiatric referral or consultation should be requested.

Even if they deny suicidal plan or intent, depressed patients with suicidal ideation and psychotic symptoms (eg, command hallucinations, delusions of control) should be hospitalized. Although some physicians use a written "no suicide" contract with patients, such a contract is not a substitute for a thorough risk assessment. Many patients who sign such a contract later commit suicide (19). Therefore, the use of these contracts gives physicians a false sense of security and provides no protection from legal liability.

Conclusion

Not all suicides are preventable, but a methodical approach to suicide risk assessment enables physicians to treat severely depressed patients and decrease the morbidity and mortality rates among those who make serious suicide attempts. In addition, the stress of identifying and managing a potentially suicidal patient may be reduced with an organized approach. Finally, a comprehensive risk assessment helps reduce physician liability. Although errors of judgment (ie, failure to *accurately* assess suicide potential) are inevitable, errors of omission (ie, failure to *adequately* assess suicide potential) are preventable if physicians take time to perform a thorough suicide risk assessment.

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SAD PERSONS: a mnemonic for assessing suicide risk

S ex (male)
A ge (elderly or adolescent)
D epression
P revious suicide attempts
E thanol abuse
R ational thinking loss (psychosis)
S ocial supports lacking
O rganized plan to commit suicide
N o spouse (divorced > widowed > single)
S ickness (physical illness)

Adapted from Patterson et al (12).

Dr Frierson is director, forensic psychiatry fellowship, and associate professor of clinical psychiatry, department of neuropsychiatry and behavioral science, University of South Carolina, Columbia. Dr Melikian is assistant professor of psychiatry, Medical University of South Carolina, Charleston. Dr Wadman is staff psychiatrist, Dorn VA Medical Center, Columbia. Correspondence: Richard L. Frierson, MD, Department of Neuropsychiatry and Behavioral Science, University of South Carolina/WSHPI, PO Box 202, Columbia, SC 29202. E-mail: rlf51@wshpi.dmh.state.sc.us.

Case Managers should take initiative to consider the factors described above and assess possible risk for suicide by talking with consumers.

If you believe that a consumer that you are working with is a high suicide risk, you should consult with your supervisor to determine the most appropriate actions to take.

UNIT 10: CO-OCCURRING DISORDERS

Description:

This unit describes the differences and similarities between substance abuse and mental illness, the DSM criteria for substance abuse disorders and the treatment options for co-occurring disorders. This unit also describes the principles of integrated treatment and the stages of change.

Objectives:

At the completion of this unit, participants will be able to:

1. Describe the prevalence of co-occurring disorders.

2. Describe the differences and similarities between substance abuse and mental illness.

3. Describe the parallel recovery processes.

4. Describe the stages of change.

Prevalence of Co-Occurring disorders

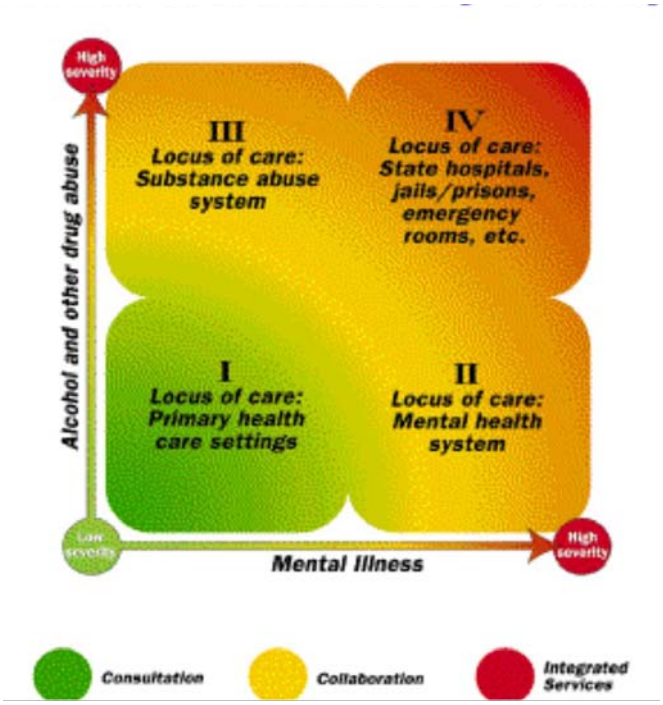
- Seven to 10 million individuals in the U.S. have at least one mental disorder and at least one alcohol or drug disorder.
- 41% to 65% of individuals with a lifetime substance use disorder also have a lifetime history of at least one mental disorder.
- 51% of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder.
- 43% of youth receiving mental health services in the United States have been diagnosed with co-occurring disorders.

Co-occurrence is associated with a variety of adverse outcomes, including:

- Symptomatic relapse
- Financial Problems
- Homelessness
- Violence
- Incarceration
- Trauma Vulnerability
- Hospitalization
- Family Disruption
- Suicide
- Sexual and Physical Victimization
- Serious Medical Illnesses (HIV, Hepatitis B & C)
- Increased Service Use - often in times of crisis

Persons with co-occurring disorders are served in many of our Systems of Care, such as Mental Health, Substance Abuse Treatment, Criminal Justice, Homeless Services, Primary Care, Victim/Trauma Services and Family Protective Services.

Service coordination by severity



Quadrant I – Less severe mental illness and substance use/Primary health care setting/ consultation

Quadrant II – More severe mental illness and less severe substance use/ Mental Health or Substance Abuse System/collaboration

Quadrant III – More severe substance use and less severe Mental illness/ Mental Health or Substance Abuse System/Collaboration

Quadrant IV – More severe substance use and mental illness/ Mental Health System/ Integrated Services

Treatment Options for Co-occurring Disorders

- Sequential Treatment– or treatment that addresses one illness before the other illness is addressed.
- Parallel Treatment- or treatment where each illness is addressed at different locations, clinicians and/or programs

Limitations of Sequential Treatment

- The untreated disorder gets worse, making it impossible to stabilize one disorder without attending to the other
- There is a lack of agreement as to which disorder should be treated first
- It's unclear when one disorder has been treated successfully so that the other one can be treated. The client is not referred for further treatment
- Different treatment providers have incompatible treatment philosophies
- Clients slips between the cracks and receives no services because the client doesn't "fit" into the existing program
- Providers lack a common language and treatment methodology
- MH and SA treatments are not integrated into a cohesive treatment package
- Treatment providers fail to communicate
- Burden of integration falls on the client
- There are funding and eligibility barriers

There are also conflicting traditions between the mental health and substance abuse systems.

Mental Health	vs.	Substance Abuse
Support		Confrontation
No self-disclosure		Therapist self-disclosure
Building self esteem		Shaming
Harm reduction		Abstinence
Agent of the consumer		Agent of the program or society
Trust		Drug testing

... and Philosophical Barriers between the mental health and substance abuse systems.

Mental Health	vs.	Substance Abuse
Professional model		Peer counseling model
Scientific treatment		Spiritual recovery
Medication		Self-help
Individualized support		Confrontation & expectation
Case management		Detachment / empowerment
Continuity of care		Episodic treatment
Deinstitutionalization		Recovery ideology
SA secondary to MI		MI secondary to SA

Parallels between Mental Illness and Substance Abuse

- Both have biological, psychological and social components
- Both create shame and guilt
- Both are stigmatized by society
- Both are primary
- Both are progressive
- Both are chronic
- Both are no fault illnesses
- People can and do recover from both

Integrated Treatment - The interaction between the mental health and/or substance abuse clinician and the individual, which addresses both the substance abuse and mental health needs of the individual.

<u>Components of Integrated Dual Disorders Treatment</u>

- Knowledge about alcohol and drug use, as well as mental illnesses
- Integrated services
- Stage-wise Treatment
- Assessment
- Motivational Treatment
- Substance Abuse Counseling

Psychopharmacology and Co-occurring Disorders

Overall Principles

- Not an absolute science
- Ongoing clinical relationship
- Continuous re-evaluation of treatment and medication
- Artful utilization of medication to promote outcome of both disorders
- Consultation when indicated

Priorities

- Safety
- Stabilization of serious psychiatric disorder
- Sobriety
- Stabilization of other psychiatric disorders

DSM-IV Criteria for Substance Use Disorders

Abuse:

- Serious problems due to substance use at home, work, or school
- Substance use putting the person in physical danger
- Substance use causing legal problems
- Continued use despite substance use-related problems with family and friends

Dependence:

- Tolerance
- Withdrawal or avoidance
- Persistent desire or unsuccessful attempts to cut down or stop substance use
- Spending a lot of time using or obtaining the substance, or recovering from its effects
- Reducing or giving up occupational, social or recreational activities in favor of substance use
- Impaired control over substance use
- Continuing to use despite physical or psychological problems

Parallel Recovery Processes

Phase 1: Stabilization

Mental Health	Substance Abuse
Stabilization of acute symptoms	*Detoxification*
Usually inpatient, may be involuntary	Usually inpatient, may be involuntary
Medication	Usually need medication
2 weeks to 6 months	3-5 days (alcohol)
Includes assessment for SA	Includes assessment for MI

Phase 2: Engagement / Motivational Enhancement

Mental Health / Substance Abuse

Both are characterized by:

- Engagement in ongoing treatment
- Motivational interviewing
- Proceeds from empathy through phases of education & empathetic confrontation to overcome denial
- Family involvement
- Engagement may take place in a variety of settings – may need extended inpatient or day treatment (Addiction Treatment 2-12 weeks – Psychiatric Treatment 1-6 months)
- Engagement may be initially coerced
- Multiple cycles of relapse may occur before engagement in ongoing treatment is successful

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Phase 3: Prolonged Stabilization

Mental Health	Substance Abuse
Continued medication adherence	*Continued abstinence*

Both are characterized by:

- Timeframe of one year
- Individual consistently takes medication as prescribed
- Usually voluntary, but ongoing compliance may be coerced or mandated
- Ongoing education and skills development
- Focus on asking for help
- Learn to accept the illness & deal with shame, stigma, guilt and despair
- Learn to cope with "negative" social, affective, and cognitive and symptoms
- Family recovery to learn to set caring limits
- Continuing assessment
- Risk of relapse continues

Phase 4: Recovery & Rehabilitation

Mental Health	Substance Abuse
Continued stability	*Continued abstinence*
Maintenance medication	*Continued 12-step group*

Both are characterized by:

- Voluntary, active involvement in treatment
- Thinking begins to clear
- New skills acquired for dealing with feelings & situations
- Takes responsibility for illness and recovery program
- Increasing capacity to work and to have relationships
- Recovery is always ongoing
- Eventual goal – peace of mind and serenity

Principles of Integrated Treatment

- First and foremost is the simple fact that people of all ages who have co-occurring disorders are people first, fully deserving of respect.
- At the same time, consumers, recovering persons and their families need to be involved in all aspects of their treatment and recovery.
- People with co-occurring disorders can and do recover.
- People with co-occurring disorders deserve access to the services they need to recover.

The eight research-derived and consensus-derived principles:

- Co-occurring disorder is an expectation, not an exception
- All integrated programs are not the same; the national consensus is the four quadrant model for categorizing co-occurring disorders
- Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting
- Provision of continuous integrated treatment relationships is an evidence based best practice for individuals with the most severe combinations of psychiatric and substance difficulties
- Case management and care must be balanced with empathic detachment, expectation, contracting, consequences, and contingent learning for each client, and in each service setting

- When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended
- Both mental illness and addiction can be treated within the philosophical framework of a "disease and recovery model" (Minkoff, 1989)
- ... with parallel phases of recovery
    - acute stabilization,
    - motivational enhancement,
    - active treatment,
    - relapse prevention
    - rehabilitation / recovery, in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change**.**

Stages of Change

People go through a process over time to recover and different services are helpful at different stages of recovery.

Pre-contemplation - Client does not acknowledge that there is a problem (spouse sent me, court ordered)

- Build rapport through empathy
- Raise doubt - not a problem, yet your spouse is threatening to leave. . .

Contemplation - The client's ambivalence is predominant.

- Allow freedom to look at both sides of it.
- Use reflections to discuss discrepancy of where they are vs. where they want to be.

Preparation -

- Client choice is emphasized
- Continued ambivalence
- To do list: smokers may smoke outside, clean/paint rooms before stopping
- Build support system for success
- Client reviews/considers options for continued treatment. -Psychiatric, residential, cognitive behavioral, DBT, group, specific programs

Action

- Active treatment
    - psychiatric: medication
    - cognitive behavioral therapy
    - group therapy
- Client working on changes
- Ambivalence will continue to surface

Maintenance

- The client sustains the new behavior - 6 months, 12 months. . .
- Continuing to develop new skills and strategies as needed.
- Potential risks to relapse are continually identified and addressed as needed.

Relapse - A normal part of the process of lasting change.

- Relapse is objectively examined, but without shame or moralizing (client feels safe to return)
- Assist client in getting back on track. Work on ambivalence, fear, self-judgment
- The client resumes action with renewed determination and an adjusted change plan.

Schizophrenia

- Pre-contemplation - do not have an illness, or not aware that symptoms are increasing
  - Danger to self/others, forced hospitalization
  - Crisis stabilization unit

- Contemplation
  - Recognizes medications changes symptoms, but does not like side effects, etc

- Preparation
  - Plan for leaving hospital, where to receive services, set up appointment
  - Return to services, set up appointment
  - Support for follow through on taking medication
  - Ambivalence (whether to continue medication)

- Action
  - Keep follow up appointment
  - Engage in services
  - Client centered
  - Active treatment
  - Ambivalence

- Maintenance
  - Symptoms stable
  - Engaged in appropriate level of treatment

- Relapse
  - Symptoms increase
    - Client engaged in treatment yet symptoms increase
    - Engage in continued treatment with support
  - Symptoms increase
    - Client ambivalence about medication has resurfaced and other decisions made
    - Using reflections focus on ambivalence and client's autonomy

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- Each stage from contemplation to maintenance has ambivalence

- Evaluate denial or resistance as ambivalence or lack of awareness of symptoms

- When resistance/defensiveness/denial surfaces, back off, check out which stage of change that client is in.

- When client is in contemplation, and we are working from an action stage, there will appear to be defensiveness (consider ambivalence)

- Work with client at the stage they are in today – may be different from yesterday or last week

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Group Therapy

- Different clients can be in different stages and in the same group.
- Addressing the groups concern over what others are doing according to what stage they are in.

UNIT 11: SUPERVISION

Description:

This unit describes the team process through group supervision as well as the importance of on-going individual supervision. This unit also reviews time management and stress management concerns that effect case managers daily.

Objectives:

At the completion of this unit, participants will be able to:

1. Identify three advantages of group supervision.
2. Understand the role of case management supervisors.
3. Understand the role of case managers in supervision.
4. Describe how group supervision can be used to assist in goal planning.

Group Supervision

In the Rehabilitation and Recovery model of case management, case managers plan and learn as a group under the supervision of a professional experienced in working with persons with severe mental illness.

There are three strong advantages to this group model of supervision:

First, research has found that in order to provide good quality service to this population, highly individualized plans must be developed for each consumer. This requires a high degree of creativity which is difficult to achieve consistently as an individual worker. However, the "brain storming" method of problem solving and generating alternatives is not only highly effective, but can also be very exciting and challenging to those involved in it.

Second, in addition to the group supervision model resulting in a higher quality of individualized planning, and therefore service, it is also an effective way of exchanging information (e.g., what resources exist and how to gain access to them) and of learning. Case managers learn ways of understanding many consumer situations and needs in addition to the cases for which they are directly responsible. Consumer needs and goals can be behaviorally anchored to the various perspectives that the individual team members bring to the group. This enhances the learning possibilities for the team members and provides a rich outlook in terms of the change strategies available to the consumer.

The **third** advantage of this group model is that it has the potential to decrease the level of "burnout" that case managers may experience. As case managers become involved in one another's cases, there is an opportunity to share successes and challenges, which provides a much higher level of support than would be possible without the group. Frustrations can be ventilated from the perspective of understanding that other team members can understand the level of challenges that case management work entails.

Roles of Case Management Supervisor

- **Consultant**--First line consultation. It is better to talk out ideas before trying them. You may help case managers to work with consumers to establish short term goals that will show progress.

- **Counselor**--Supervisors are not therapists for their staff. However, it is appropriate to help workers through stressful times by reflecting, showing empathy, building rapport, and facilitating growth.

- **Teacher**--Model and teach skills**.** This is an on-going process which needs patience and preparation. When you identify a need to learn, check it out with the group. Determine who should present what information at the next group supervision.

- **Supervisor**--Understand your role and its limits. Be clear and model a strengths model value base, energy, and a "can-do" attitude. Show respect and loyalty.

- **Administrator**—Provide agency updates and overall requirements that will assist case managers in completing tasks efficiently and decrease isolation.

- **Colleague**--You share common professional goals even when other professions don't think alike.

- **Facilitator**--You are a catalyst for the case managers. (But not all things to all people.) You can assist the group in identifying consumer specific or system specific issues and strategize ways to move forward. You can refocus a difficult group supervision session by asking each case manager to share a goal a consumer achieved or an experience that caused "a bright case management moment".

Roles of Case Manager

Because of the high level of involvement that case managers have in the work and learning processes, there are certain basic rights and responsibilities that accompany membership in the case management team. Some of these are listed below.

- All members are expected to participate both in listening to and contributing ideas. No ideas are too "silly, absurd, or simple" to be useful and, in fact, ideas that may seem to initially fit one of these descriptors are often the seeds of the best plans.

- Each member will find that there are areas in which they have skills and areas where they have skill deficits. It is important to remember this and to be willing to bring problems, apprehensions, frustrations, confusion and/or recommendations to the group for help. That is a part of the learning process.

- Because the team may spend a great deal of time together, it is important to promote a comfortable, informal atmosphere. Humor is a vital part of such an atmosphere. The ability to laugh is a survival skill.

- All members are expected to accord the other team members the same respect and sensitivity to which you are entitled.

- Approach the group process with an open mind. Remember that personal biases do exist. It is important to acknowledge these biases but also be willing to set them aside. By letting go of stereotypic notions, freedom to enter into the creative process of exploring intervention alternatives will be enhanced.

Alternative Group Strategies

The strengths model of case management outlined in this manual is designed to utilize group supervision or the team concept as a means of enhancing the intervention strategies available to case managers and consumers. The group process is intended to be flexible depending upon the level of staff expertise and situational needs. For example, with a new staff, initial group sessions may focus on more formalized presentations of local resources, strengths, assessment, etc. Through these formal presentations, staff members can be familiarized with a number of assessment strategies and how to conceptualize consumer strengths which will begin to focus the intervention strategies. As the group becomes more comfortable working together as a team, the formalized nature of the group process will decrease. It is important that the group members perceive the group as a time for mutual creativity and support to enhance their effectiveness in working with persons with SMI.

It is important to also identify needs of group members. For example, if case managers discuss concerns about communicating with someone who is hallucinating, the group may chose to watch a video during their next meeting to enhance their skills or, if psychotropic medications are causing confusion, a staff nurse or community pharmacist may be invited to provide a brief presentation.

Taking Care of Yourself

Working with people can be stressful. Working with persons who are low income and who suffer from severe mental illness can be even more stressful. It is important to take care of yourself – physically, emotionally, and socially. You may have opportunities to attend time management and stress management workshops. They will go into more detail about coping with the challenges of your job. But here is a list of suggestions that may be useful:

Time Management

- Make a daily plan of tasks.
- Prioritize the list. Identify those tasks that have to be done today (A's) from those which should be done, but could be done tomorrow (B's) and those which are not that important (C's).
- Be sure to do your "A" tasks first.
- Keep lists simple and realistic.
- Carry your list with you – consult it often.
- Let your list be your guide, not a ball and chain. You will find that you often have to adapt and revise.
- Let the consumers know when you will have time to provide transportation, go shopping, etc. Set appointments with them and stick with it. If they are not there for the appointment, make another appointment for another time. They will soon know they can rely on you.
- Be on time. Treat consumers the way you want to be treated.

- Make a "grass-catcher" list. This is an ongoing list of things to be done, but do not have a specific deadline. When you are making your daily to-do list, consult this "grass-catcher" list.
- Always ask "what is the best use of my time right now?"
- Do not do other people's "A" tasks at the expense of your own.

Stress Management

- Talk with co-workers and your supervisor about your experiences and feelings. Sharing with others helps to reduce the tension and find humor in difficult situations.
- Learn how to use relaxation exercises.
- Use humor appropriately.
- Recognize the stages of burnout.

Stage I – Early Warning Signs	Stage II – Initial Burnout
Vague anxiety	Lowered emotional control
Constant fatigue	Increasing anxiety
Feelings of depression	Sleep disturbances
Boredom with one's job	Headaches
Apathy	Diffuse back and muscle aches
	Loss of energy
	Hyperactivity
	Excessive fatigue
	Moderate withdrawal from social contact

Stage III – Burnout	Stage IV – Burnout
Skin rashes	Coronary artery disease
Generalized physical weakness	Asthma, Diabetes
Strong feelings of depression	Cancer, Heart attacks
Increased alcohol intake	Muscle tremors
Increased smoking	Suicidal thoughts
High blood pressure	Severe depression
Ulcers	Lowered self-esteem
Migraines	Inability to function at job/home
Severe withdrawal	Uncontrolled crying spells
Loss of appetite for food	Severe withdrawal
Loss of sexual appetite	Severe fatigue
Excessive irritability	Over-reaction to emotional stimuli
Emotional outbursts	Agitation, Constant tension
Irrational fears (phobias)	Feelings of hostility
Rigid thinking	Accident proneness/carelessness

- Take action to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.

- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits for yourself and others. Know your own boundaries.
- Exercise regularly.

"Often the person who identifies himself as the curer or fixer-type healer is vulnerable to burnout" *(Rachel Naomi Remen, M.D.).*

"Perhaps the most important thing I have learned from my work is that I can be a friend and supporter of healing; I can be a guide to people; but it is not I who does the healing. I try to heal by creating situations that seem to allow or foster healing – calmness, faith, hope, enthusiasm – and sometimes just the idea that healing is a possibility" *(Martin Rossman, M.D.).*

Appendix I

Kentucky Adult Targeted Mental Health Case Management Training Manual

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Appendix II

Kentucky Adult Targeted Mental Health Case Management Training Manual

On-line Training

The Kentucky Department for Mental Health and Mental Retardation Services' certification training for Case Managers who serve adults with severe mental illness is provided on-line through the Kentucky Department for Public Health's **TrainingFinder Real-time Affiliate Integrated Network (TRAIN)** (http://ky.train.org) web-based training system. After creating an account on the TRAIN system, participants will be able to access available courses. (Search for: Case Management Training).

The training is designed to fulfill training requirements established by the Department for Medicaid Services (DMS) and the Department for Mental Health and Mental Retardation Services (DMHMRS) for Adult Targeted Case Managers. All case managers who serve adults with severe mental illness, and whose services are reimbursed by the DMS and the DMHMRS are required to complete this certification training within six months of beginning to provide the service. It is strongly recommended, however, that the on-line training be completed as soon as possible after beginning to provide case management services.

The training is not intended to provide all of the knowledge, skills and information that is necessary to provide excellent quality case management services. It is intended to provide a basic overview of the service, information necessary for compliance with statutes and regulations, and a knowledge base upon which further training, education and supervision can build. Case Managers can proceed at their own pace, and delve in more depth into content areas that are important to case managers as they carry out their work.

There is also a final assessment to assure that key information has been understood. Successful completion of the test is required before the certificate of completion can be obtained.

As you proceed through the training, you will have an opportunity to follow links to documents and web pages. Some of these resources are a necessary component of the training, and should be read in their entirety. Others are resources that you should bookmark in your own web browser for future reference, as they will be valuable to you as you continue your work in the field.

Following are a few basic resources that you should be sure that you bookmark in your web browsers.

The Department for Mental Health and Mental Retardation Services' Training Manual can be accessed at: http://mhmr.ky.gov/mhsas/prog_01.asp

The link to the Manual is near the bottom of the page, along with other resources associated with Adult Targeted Case Management services.

The Department for Medicaid Services has regulations and manuals associated with their regulations posted on their website. The regulation for Adult Targeted Case Management is at: http://www.lrc.state.ky.us/kar/907/001/515.htm

The details regarding implementation of regulatory requirements are included in a Manual, which can be accessed at: http://chfs.ky.gov/NR/rdonlyres/5314BF79-BDC2-4A08-883E-4D839A0340E4/0/1550.pdf

The Department for Medicaid Services also has regulations and manuals that apply to other services provided by the system of Community Mental Health Centers throughout the state. This information may be important for you to refer to.

The Medicaid Community Mental Health Center Regulation can be accessed at: http://www.lrc.state.ky.us/kar/907/001/044.htm

The Manual associated with this regulation can be accessed at: http://chfs.ky.gov/NR/rdonlyres/AB21A40E-D763-4F8F-9874-A71300B2AFD1/0/1044a.pdf

The main Department for Mental Health and Mental Retardation Services website, with much valuable and important information, is located at: http://mhmr.ky.gov/kdmhmrs/default.asp

The main Department for Medicaid Services website, which also includes much useful information, can be accessed at: http://chfs.ky.gov/dms

Other useful resources are:

Kentucky Revised Statutes: http://www.lrc.ky.gov/krs/titles.htm

Kentucky Administrative Regulations: http://www.lrc.ky.gov/kar/titles.htm

Medicare: http://www.cms.hhs.gov

Department for Health and Human Services – current poverty guidelines: http://aspe.hhs.gov/poverty/07poverty.shtml

Social Security Administration: http://www.ssa.gov/

Kentucky Transitional Assistance Program (K-TAP): http://chfs.ky.gov/dcbs/dfs/KTAP.htm

Veterans Administration Benefits: http://www.vba.va.gov

Local Health Departments: http://chfs.ky.gov/dph/Local+Health+Department.htm

Food Stamps: http://chfs.ky.gov/dcbs/dfs/foodstampsebt.htm

Women, Infants and Children (WIC): http://chfs.ky.gov/dph/ach/ns/wic.htm

Salvation Army: http://www.salvationarmyusa.org

Kentucky Department for Vocational Rehabilitation: http://ovr.ky.gov

Community Action Agencies: http://www.kaca.org

Department for Housing and Urban Development: http://www.hud.gov

Kentucky Housing Corporation: http://www.kyhousing.org

Wellspring (Louisville): http://www.wellspring-house.org

New Beginnings, Bluegrass (Lexington): http://www.newbeginningsbg.org

Appendix III

Kentucky Adult Targeted Mental Health Case Management Training Manual

Case Management Forms

ASSURANCE OF CASE MANAGEMENT SERVICES CERTIFICATION FORM

I. CLIENT INFORMATION

Client Name _____Birthdate_____

Medical Assistance Identification Number_____

Address of Client_____

Responsible Party/Legal Representative_____

Address_____

_____

II. CERTIFICATION

Targeted Case Management Services – This is to certify that I/responsible party/legal representative have been informed of my rights with regard to Case Management Services.

I elect _____ or do not elect _____ case management services.

I choose _____ as my Case Management Provider.

I choose _____ as my Case Manager.

_____ _____

Signature Date

_____

Signature and Title of Person Assisting with Completion of Form

Agency_____

Address_____

TRANSMITTAL #1

CASE MANAGEMENT STRENGTHS ASSESSMENT

Consumer:_____Age:_____Sex:_____Date:_____

Address:_____Social Security #:_____

Case Manager:_____Consumer #_____Medicaid #
_____

Date of most recent Discharge from institution:

Marital Status	Educational Status (check all that apply)	Race/Ethnicity
____Divorced/annulled	____1 to 5 years	White _____
____Widowed	____6 to 8 years	Black_____
____Separated	____9 to 10 years	Hispanic_____
____Common law/Living together	____11 to 12 years	Native American_____
____Married	____GED	Other_____
____Never Married	____Trade/vocational/training	First Language_____
____# Children - Ages:	____College	Second Language_____
____How many in house	____Graduate school	
	____Other_____.	

Sources of Monthly Income	None	Amount
SSI:_____ or SSD_____	_____	_____
Employment:	_____	_____
Vocational program:	_____	_____
Unemployment compensation:	_____	_____
T.A.N.F/AFDC:	_____	_____
Food stamps	_____	_____
Alimony/child support	_____	_____
Family/spouse contribution	_____	_____
Military service Disability	_____	_____
Pension, social security, retirement, etc.	_____	_____
Other source (specify)	_____	_____
	_____	_____

Monthly Expenses	Amount
Rent	_____
Utilities	_____
Others:	_____
	_____
	_____

	Yes	No
Medicaid	_____	_____
Medicare	_____	_____
Private insurance	_____	_____

Other information: (Should include legal status)

CASE MANAGEMENT
STRENGTHS ASSESSMENT

_____ _____

CASE MANAGER NAME, TITLE DATE **CONSUMER NAME ID NUMBER**

CURRENT STATUS WHAT'S GOING ON NOW?	PERSONAL GOALS WHERE I'D LIKE TO BE?	RESOURCES: INTERNAL/EXTERNAL WHAT HAVE I USED? WHAT CAN I USE?	NEEDS WHAT STEPS DO I TAKE TO GET THERE?
Filling out these two columns in each of the life domains will provide for a good consumer assessment.		**Filling out these two columns will help develop a foundation for a good consumer-driven personal plan.**	
LIVING ENVIRONMENT: MY LIVING SITAUTION			
LEARNING ENVIRONMENT: MY EDUUCATIONAL AND LEARNING INTERESTS ARE…			

CASE MANAGEMENT
STRENGTHS ASSESSMENT

_____ _____

CASE MANAGER NAME, TITLE DATE **CONSUMER NAME ID NUMBER**

CURRENT STATUS WHAT'S GOING ON NOW?	PERSONAL GOALS WHERE I'D LIKE TO BE?	RESOURCES: INTERNAL/EXTERNAL WHAT HAVE I USED? WHAT CAN I USE?	NEEDS WHAT STEPS DO I TAKE TO GET THERE?
Filling out these two columns in each of the life domains will provide for a good consumer assessment.		**Filling out these two columns will help develop a foundation for a good consumer-driven personal plan.**	
WORKING ENVIRONMENT: I SPEND MY TIME...			
SOCIAL ENVIRONMENT: WHO IS IMPORTANT IN MY LIFE			

NEEDS LIST

NEEDS **(From needs section of the assessment tool)**	**PRIORITY** **(1 = highest)**

INITIAL TASK:

Case Manager's Name	Date

PERSONAL PLAN

Consumer's Name	ID #

Life Domain (check one): ☐ Living Environment ☐ Learning Environment ☐ Working Environment ☐ Social Environment

Long Term Goal:

Short Term Goals and Action Steps	Responsibility for C/CM/Specialist	Date to be Accomplished	Date Accomplished	Comments
Short term goal:				

_____ _____ _____ _____

Consumer Signature date Case Manager Signature date